

Fault Lines in the Shifting Landscape:

The Future of Growing Older in California—2010

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ABOUT THE INSTITUTE FOR THE FUTURE ...

Located at the northern edge of Silicon Valley in Menlo Park, California, and at the heart of Multimedia Gulch (SOMA) in San Francisco, the Institute for the Future (ITF) is an independent, nonprofit research firm that specializes in cross-industry, long-term forecasting. Founded in 1968, ITF has become a leader in action-oriented research for business, industry, and government.

For 30 years, we have identified trends that have transformed the marketplace and analyzed the impact of those trends on our clients' businesses, working with them to develop strategic responses to the emerging opportunities and threats across the business landscape. We focus on general demographic and economic trends, with a special emphasis on emerging information technologies and health care.

ABOUT THE ARCHSTONE FOUNDATION ...

Archstone Foundation's mission is to contribute toward the preparation of society in meeting the needs of an aging population. Our resources are used to help all generations plan for the aging process and support programs addressing the needs of the elderly in three areas:

- healthy aging and independence
- quality of life within institutional settings
- at the end of life



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FOREWORD

Four years ago the Archstone Foundation Board of Directors decided to redirect the funding priorities of the Foundation from the health concerns in the entire life cycle to those in the later stages of life. As a part of our learning journey we invited the Institute for the Future to work with us on identifying key future trends and issues that may impact the aging population and the needs they face as we move into the 21st century.

This report is intended to be a tool to help policymakers, funders, planners, members of the aging network, and educators look to the long-term needs and opportunities presented by the aging of our population.

Our vision is that by thoughtful, informed planning, we can direct our resources in the most effective ways and that we can avoid some of the pitfalls. We hope that this publication will be a tool that can be used in each of our individual spheres of influence. Working as a group it can help prepare California to be a vital elder-friendly community where all of her residents can maximize their health and well-being, and be engaged and living independently for as long as possible.

Joseph F. Prevratil
President and Chief Executive Officer
Archstone Foundation



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ARCHSTONE FOUNDATION SUPPORT

The Archstone Foundation provided the fundamental support for the research and report. Special thanks go to Joseph Prevratil, president and CEO of Archstone, for his leadership in focusing Archstone Foundation programming solely on aging and for his confidence in IFTF to complete a long-range forecast to help understand aging in California. John Knox, chairman of the Archstone Foundation Board, remains an inspiration for his commitment to informed public policy and his determination to help facilitate better public policy on aging. Dr. Len Hughes Andrus, board member, was tireless in his review of our work, and helped to balance the focus on medical and social issues and to address the importance of remembering that aging is a normal process, not a disease. The rest of the board members were supportive and enthusiastic throughout the process. Mary Ellen Courtright is a superb vice president and program officer, and she helped us in every way. Sandra Lund, vice president of planning and communications, was critical to our decisions on how to best share our work around the state and nation.

OTHER FOUNDATION SUPPORT ...

Support from other foundations was critical to our work. While we were completing the report, the Robert Wood Johnson Foundation provided funding to IFTF to complete a long-range forecast of American health care, which included extensive research on aging, Medicare, and chronic disease. This research was used extensively in our report and helped us look realistically at the pace of change in federal programs and see California in a national context. The California Health Care Foundation supported a forecast of Medicare managed care in California and the impact of the Internet on health care. Both projects were critical complementary pieces to our work. Prior to our study of growing older in California, we received support from both the Archstone Foundation and the Henry J. Kaiser Family Foundation to look

out at the future of California health care, and the future of the safety net in particular. We built extensively upon that work.

INSTITUTE FOR THE FUTURE SUPPORT ...

IFTF's health care program is continuously researching the future of a variety of health care issues. Our work would not have been possible without this knowledge base. Special thanks go to Wendy Everett, who leads our health care program, for generously sharing relevant data and perspectives. Robert Mittman, a health care director, contributed overall review, helped us with the technology and health care sections, and participated in our forecasting work. Mary Cain, health care research manager, provided important reviews and helped us track down hard-to-find data to support our analysis.

REVIEWERS, COLLABORATORS, AND THINKING PARTNERS ...

We would like to acknowledge the individuals who spent considerable time reviewing and commenting on the various sections of this report or worked in collaboration with us to understand the diverse and complex issues of California's aging future. We extend thanks to Shirley Chater, PhD, Institute for Health and Aging, UCSF; Lynn Friss Fienberg, Family Caregiver Alliance; Glen Gilbert, Senior Net; Jennie Chin Hansen, On Lok, Inc.; Aileen Harper, Center for Health Care Rights; Deborah Reidy Kelch, Kelch & Associates; Derrell Kelch, California Association of Area Agencies on Aging; Brenda Klutz, California Department of Health Services; Paul Minnicucci; Tom Porter, Public Interest Center on Long Term Care; Laura Reif, PhD, UCSF; Dorothy P. Rice, Professor Emeritus, UCSF; Terry Rooney, San Mateo County Health Services; Charlene Silva, San Mateo County, Aging and Adult Services; Kellie Takagi, Veteran Affairs—Palo Alto Health Care System; Gwen Yeo, PhD, Stanford Geriatric Education Center; and Sepi Djavaheri.



Introduction

THE FUTURE OF GROWING OLDER IN CALIFORNIA

The entire aging landscape of California is changing dramatically. This report is intended to provide a broad overview of the key driving forces that will shape the future of growing older through the next decade and beyond, not to present a comprehensive review of aging in the state. This report also offers a brief look at the aging of America, to provide a context for understanding how the complexity and size of the Golden State's aging challenges differentiate it from other places.

California will experience two major demographic shifts: in aging and in diversity. California is aging faster than the United States as a whole, and it is already undergoing broad economic and demographic changes that are likely to continue to transform the experience of the many cultures California represents. The number of people belonging to racial and ethnic groups makes up just over 50% of the population, so the future is already here. The United States will not reach California's current level of cultural diversity until 2050.

California is pioneering an aging diverse society, and can serve as a model to other states, even though its aging context is unique. For example, California will struggle with the increasing gap between the wealthy and the poor elderly more so than will other states.

California's aging population raises many concerns for public and private decision makers, yet information about aging in the state is fragmented, uneven, and uncataloged, and rarely has been synthesized for decision making. No one has a "big picture" perspective on

California's aging population or the critical issues it faces. This report pulls together the existing information and looks at six drivers and nine critical issues that California needs to address from 2000 through 2010, to avoid unpleasant surprises later on when it may be too late

to address them rationally. None of these issues will be resolved in the next five to ten years. Still, it is possible today to begin building the social infrastructure needed to support the looming increase in the aging population in future decades.

The year 2010 will be a benchmark year. It will mark the end of two decades during which the growth of

California's elderly population will, in all likelihood, have been relatively slow. Experts project that the change after 2010 will be dramatic, as the annual average growth rate of the 65+ population will nearly double, increasing their numbers from 10% to almost 17% of the population by 2030. Resources in every sector of society will have to be mobilized to serve them. Thus, the first decade of the 21st century truly will be the calm before the storm.

This graying of California will have profound implications for all aspects of our society—from health care to housing, from politics to business. We can see the very early stages of these changes already, although their full impact will be felt more toward the year 2010, when the first baby boomers turn 65. We hope this report will help make sense of this future while providing some guideposts for creating a better life for all Californians.

California is pioneering
an aging diverse society,
and can serve as a model
to other states.



EXECUTIVE SUMMARY

The graying of California will have profound implications for all aspects of society. With a larger population of elders and greater ethnic diversity than the United States as a whole, California is pioneering a model for meeting the challenges of a dramatic demographic shift.

This report provides a broad overview of the key forces driving change in a multicultural aging society and insights into selected critical issues that create a context for understanding the complexity of California's changing society. It focuses on what to expect between now and 2010 and provides a window into the future human tidal wave of elders beyond 2010.

The report also explores shifts in thinking and strategies to prepare now for what lies ahead. Among these shifts are approaches to caregiving, changes in public policy, reconfiguring communities, and revising outmoded attitudes about aging to maximize the productivity and value of the elderly in society.

CHAPTER 1

Drivers of Change: Six Fault Lines Are Shaping the Future of Growing Older in California

This section examines six driving forces that will transform the entire social structure of California over the next 20 years. Extensive data collection and analysis support forecasts about the magnitude and timing of impact for each of these forces.

1. The Aging Population and Its Growing Diversity

The number of older Californians is growing dramatically, at a much faster rate than in the nation as a whole. This number will continue to grow well into the next century with the aging of the huge baby boom generation.

Increasing diversity will also characterize this demographic shift, with growing polarization among older Californians, and widening gaps in influence, education, and income as well as in gender, race, and ethnicity. Of particular note is the rapid growth of California's oldest old, women over 80, most of whom will be single.

2. The Changing Role of California Women

California has seen dramatic changes in the way women live and work over the last half of the 20th century, especially women who entered adulthood in the late 1960s and beyond. Through their investment in education, jobs, and technology—and their involvement in their communities and California's political process—they are creating new identities and roles and having more impact. Women contribute a large share of household income and attain most of the state's undergraduate degrees. They are not likely to accept historic stereotypes of the elderly, but they will approach aging creatively, demanding greater involvement in the decisions that affect their lives.

3. California's Older New Consumer: Sophisticated and Savvy

Among California elders is a dominant subgroup of high achievers. These people have attained high levels of education and income and are becoming technologically savvy. They have access to information about the latest medical and social trends, and are changing their lifestyles in order to maintain longer and healthier lives. This group will drive the elder marketplace and policy agenda.

4. Low Savings and Inadequate Retirement Income

In contrast to the “older new consumers” are the hidden poor and near-poor elders who grow poorer as they experience the new longevity. Most people expect to enjoy an undiminished standard of living in retirement, but many Californians are not saving enough, and may have to work well past 65 in order to meet their own needs.

5. The Continuing Increases in Health Care Costs

Controlling health costs will remain a challenge particularly for the elderly. Overall health costs, for the individual and for society as a whole, will continue to rise steeply, possibly at double the rate of overall inflation.

6. New Information and Medical Technologies

Over the next decade, the lives of older people are likely to be impacted significantly by new technologies. The revolution in communication and information technologies is beginning to affect the health management and social life of elders through increased connectivity between family, friends, medical care providers, and information. Equally important are medical technologies that will come of age over the next ten years to dramatically increase the effectiveness of diagnosis and early treatment of disease, circumventing costly and debilitating effects: rational drug design, medical imaging, minimally invasive surgery, genetic mapping and testing, gene therapy, vaccines, and xenotransplantation.

CHAPTER 2

Intersections: Drivers and Critical Issues to 2010

This section of the report provides a forecast of elder issues to the year 2010 in the form of an extensive matrix, linking the six drivers listed above with nine critical issues.

CHAPTER 3

Nine Critical Issues: The Shifting Landscape of Growing Older in California

This section takes an in-depth look at nine immediate or ongoing critical issues.

1. The New Pioneers: 80-to-100-Year-Old Californians

Life expectancy in 1900 was 47 years of age. Now a growing number of Californians are living into their 80s and 90s, and some will live past 100 years of age. Today’s 80-year-old Californians are truly pioneers. Most never expected to be living this long and living this well. This population in the coming years will be ethnically diverse, mostly women and single. Roughly half will be healthy and productive; the other half will be sickly and need a multitude of costly services not readily available.

2. The Haves and the Have-Nots: Growing Polarization Among the Elderly

The number of older Californians is growing at both ends of the income scale, creating two profoundly different groups of people. Those with incomes over \$50,000 are predominantly white, a trend that will accelerate as white wealthy baby boomers age. Those with incomes under \$15,000 are for the most part people of color, a trend that will also accelerate as “boomers of color” age. At the present time, richer and poorer older populations are invisible to each other, living in different neighborhoods and ethnic and racial communities. A detailed examination of the income, lifestyle, and health patterns of people across the economic spectrum demonstrates the link between economic and physical health. With increasing polarization in income levels, the gap in understanding between people of different cultural backgrounds is a significant and pressing issue.

3. California's Ethnically Diverse Older Population: The Rich Legacy of Many Cultures

The demographic shift in California is moving toward an increasingly multicultural and multilingual population. Yet lack of information about ethnic diversity has stymied the growth of effective programs and policies, leaving these growing populations invisible. Different ethnic groups often have different cultural traditions and ideas about aging that health and social service providers fail to address. An in-depth look at geographic distribution of ethnic elders and their cultural, economic, and social conventions sheds light on ways to provide better access to services.

4. The Growing Vulnerability of Older Women

Single older women are growing increasingly vulnerable. Older women constitute the majority of the elderly population—particularly those over 85—and they are vulnerable to poverty and declining health. Already, women who reach age 65 have a life expectancy of almost 19 more years, compared to 15 for men. Most face income, health, and social challenges that are not being addressed by public policy and existing social services. Health facts and an examination of the unique combination of challenges faced by elder women offer insight into social and health care solutions.

5. Elder Medical Care: Fragmentation of Financing, Programs, and Services

Because California has no organized system of elder care or long-term care delivery, both the financing and the delivery of elder-care services are seriously fragmented, resulting in inefficiencies and high costs. The types of problems facing older Californians today are the same as they were in the 1980s. A patchwork of categorical programs designed to alleviate these problems has instead created a tangle of administrative directives, eligibility

issues, turf battles, and duplicated services. Taken as a whole, this disorganized system becomes a formidable barrier, preventing innovative or comprehensive solutions. A study of this morass produces a discouraging outlook for the future, but also some examples of innovative programs and trends that, while cost-driven, represent positive change, such as disease management and nursing home alternatives.

6. The Housing Challenge: A Growing Need for Senior Housing and Community-Based Services

For many years, experts in the field have warned of a looming crisis in housing and older Californians' growing need for community-based services. By most estimates, that crisis has arrived, creating the most severe short-term problem currently facing California elders. This is compounded by California's high cost of housing. A comprehensive housing policy is needed but unlikely to emerge for ten years. The outlook is for increasing fragmentation on the policy level that will result in experimentation by institutions and individuals seeking innovative housing and long-term care solutions. Some of the grassroots solution-seekers will be pioneers in community building, networking, and resource sharing that will not only meet the need for shelter but also will strengthen human connections.

7. The Caregivers' Conundrum

Contrary to perceptions that the elderly are abandoned by their families, most elder care, about 80%, is provided by family, friends, and neighbors. Caregiving is very much a family and local community function. As the number of very old grow over the next two decades and the scale of caregiving needs skyrockets, families and communities no longer may be able to cope. Even the caregivers are becoming older and more frail. More women are working, families are smaller and geographically dispersed, and many California households of older people are

headed by single women. Although more services are becoming available in some communities, they are fragmented. This maze of uncoordinated health and social programs makes it difficult for families to identify and obtain help. Services are further compromised by a current and growing crisis in the lack of availability of paid caregivers. A study of the shrinking pool of caregivers has implications that will affect individuals, families, and public policy.

8. California's Aging Workforce: Challenges and Opportunities

The 20th-century notion of retirement at 65 becomes obsolete as people live to be 90 and older. Over the past several decades the nature of jobs has changed, enabling older people to easily work longer. It's their brains not their brawn that counts. More older Californians will work by choice and need. The workplace will be characterized by many conflicting trends such as discrimination against older workers and a shortage of workers. The outlook includes shifts in working habits that represent a mixed bag, such as more flexibility but less security.

9. California Community Readiness: Regional Maldistribution of Resources

Great regional differences exist in the range and scope of services available to California's older population. Regional demographic shifts will continue to be significant in the years ahead as the highest growth rates will be in the counties with the least resources to address them. A demographic analysis that compares different regions finds that Los Angeles and Southern California will be the most challenged, with the fastest growth of underserved elders in several inland areas. Preparation is not in the forecast, except in some wealthy or socially progressive areas that will become laboratories for experimental programs for elders.

CHAPTER 4

Guiding Principles: Final Thoughts

The report concludes with a set of eight principles to guide decision makers. Each of these principles suggests several specific strategies—opportunities for action that could make a difference, including:

- *Invest in the education and development of California's diverse youth* to ensure a future knowledge workforce, critical for maintaining the institutions and tax base that support quality of life for elders.
- *Build a knowledge foundation on aging* by pulling together fragmented data and encouraging elders to contribute with their experiences, particularly the ethnic groups that are relatively invisible outside their own communities.
- *Foster the development of leadership in aging* by convening innovative groups with a fresh outlook, supporting education of elders, and forming coalitions of ethnic elders to influence policymakers and health care providers
- *Chip away at essential public policy* by educating legislators—locally, statewide, and nationally—on aging issues.
- *Educate the public about successful aging* by combating negative stereotypes, educating businesses about the value of older workers, tapping into the entertainment industry, and rating communities based on their support of elders.
- *Direct the most attention to older women* because women represent the largest and most vulnerable sector of the elder population—bring the issue to women's organizations, develop community programs connecting younger and older women, support research on aging women, and focus on women of color.

- *Innovate at the family and community levels* by supporting model communities, creating prototype high-tech model communities, and broadcasting examples of what works.
- *Address poverty and maldistribution of resources* by exploring employment opportunities for elders in the role of community resources, initiating public policies that direct more revenue to communities with poor and underserved elders, and creating a new index of poverty and aging for California elders.

Drivers of Change

SIX FAULT LINES ARE SHAPING THE FUTURE OF GROWING OLDER IN CALIFORNIA

Throughout its history, California has experienced constant and rapid evolution both socially and economically, reflecting in its human dimensions the same kind of tectonic forces that continue to shape the state's landscape. The future of growing older in California will closely mirror the demographic, cultural, political, and economic earthquakes, shifts, and subsidences of the state.

If we are to examine the current and near-future dynamics of aging in California, we must do so within the context of understanding the driving forces¹ that are inextricably linked to a “human tidal wave” of elderly. These forces, or fault lines, are the unmistakable drivers of change marking the points at which underlying pressures—economic, social, political, and technological—have converged and emerged at the surface, shifting the landscape of growing older in California.

California must confront these fault lines head on, for each will drive changes of such magnitude that they can transform or crack the entire social structure of California, with long-lasting consequences. The demographic fault lines that are relentlessly threatening California will intersect and combine with other trends to shape the future, increasing the potency and impact of the resulting tidal wave of elderly. The following section examines in more detail each of the fault lines and their underlying issues.

The six fault lines can be mapped as follows:

- The Aging Population and Its Growing Diversity
 - The Changing Role of California Women
 - California's Older New Consumer: Sophisticated and Savvy
 - Low Savings and Inadequate Retirement Income
 - Increasing Health Care Costs
 - New Information and Medical Technologies
-

¹Drivers are independent trends with considerable influence in shaping the future.

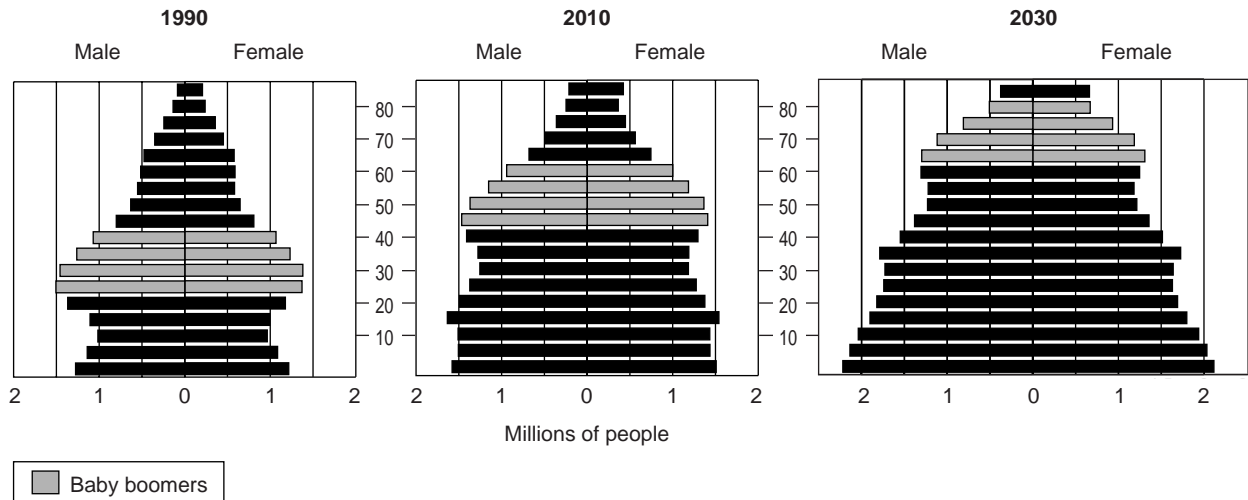
1

**THE AGING POPULATION
AND ITS GROWING DIVERSITY**

The number of older Californians is growing dramatically and will continue to grow well into the new millennium with the aging of the huge baby boomer generation, born right after World War II ended (see Figure 1–1). Increasing diversity will also characterize this demographic shift, heightening the growing polarization among older Californians and widening gaps in

influence, education, and income along attributes of gender, race, and ethnicity. In the long term, California’s population profile will not resemble most aging societies. California will have a large and diverse young cohort driven by high fertility rates and immigration into the state.

Figure 1–1
California’s Aging Baby Boomers Drive a Human Tidal Wave
(Millions of people)



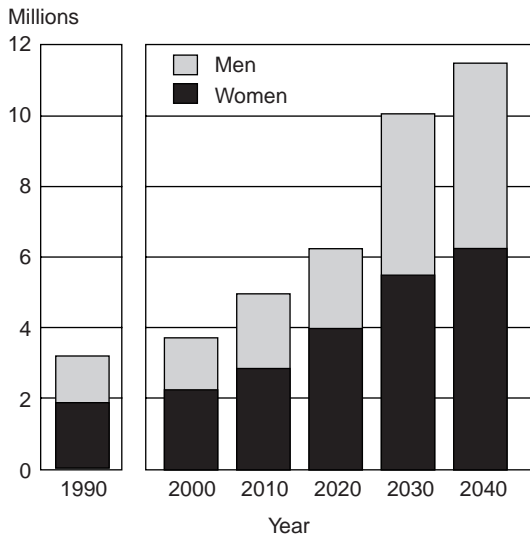
Source: California Department of Finance, Population Research Unit, Reports 88 P-4 and 93 P-3.

Rapid Growth in California's Older Population

California's elderly population—people age 65 and older—will reach 4.5 million by the year 2010, an increase of 23% from 3.7 million in 2000 (see Figure 1–2). In the coming decades, increases in the number of older Californians will be more dramatic as baby boomers enter retirement, raising the average age in the state and pushing the number of older Californians to 6.3 million by 2020. Some estimates forecast the number of

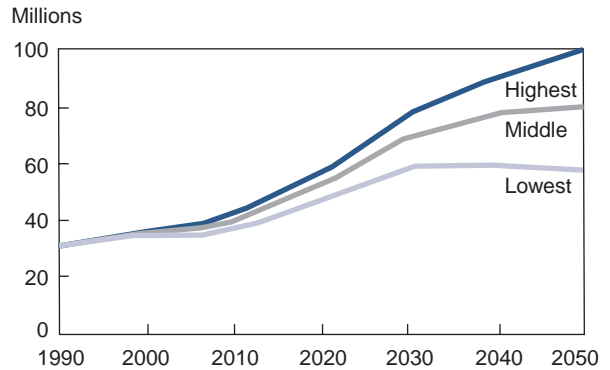
Californians over the age of 65 to be closer to 10 million by as early as 2010. However, no one knows how many elderly we will have in the future because few projections make valid assumptions about dramatically declining disability rates, which will boost overall life expectancy (see Figure 1–3). National projections from the U.S. Census Bureau reflect this uncertainty.

Figure 1–2
California's 65+ Population Will Grow Rapidly



Source: State of California, Department of Finance, *Projected Total Population, 1993*.

Figure 1–3
Projected Elderly Population in the United States—
Alternative Series, 1990–2050

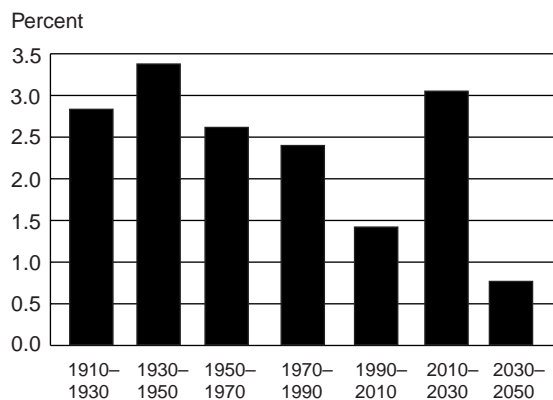


Source: U.S. Bureau of the Census. *U.S. Population Estimates by Age, Sex, Race, and Hispanic Origin: 1990–1993*. Population Paper Listing-8 (PPL-8); *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1993 to 2050*. Current Population Reports, Series P-25, No. 1104. Washington, DC: USGPO, 1993.

Fast-Paced Growth Between 2010 and 2030

California, the most populous state, together with the nation as a whole will experience a long-term burst of growth in the 65+ age group not seen in the nation since the 1930s (see Figure 1–4). The average annual growth rate of people 65 and older will, however, be higher in California than in the country as a whole (see Figure 1–5).

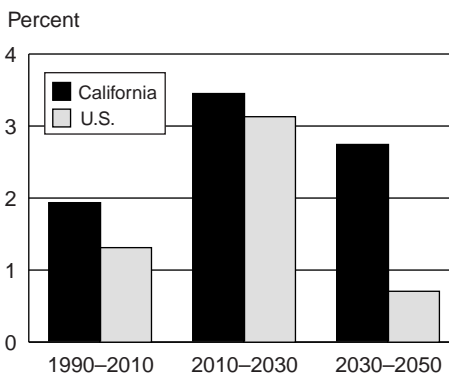
*Figure 1–4
National Average Annual Growth Rate of the Elderly Population, 1910–2050*



Source: IFTF; U.S. Census Bureau.

Despite the looming challenges, few policymakers in the private *or* the public sector have moved beyond thinking about the future to mobilize resources that will meet the needs of this dramatic “human tidal wave.”

*Figure 1–5
Average Annual Growth Rate Is Higher in California Than in the United States*

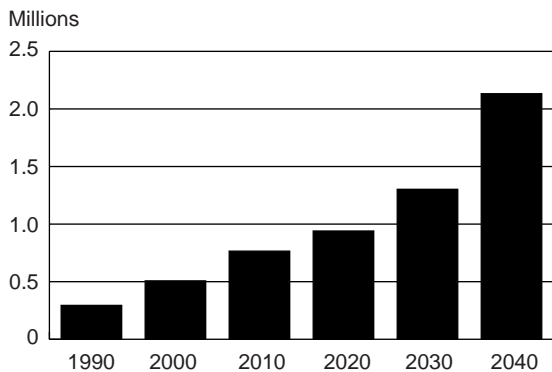


Source: IFTF; State of California, Department of Finance; *Statistical Abstract of the United States*.

Growth of the “Oldest Old”

The number of the “oldest old”—people age 85 and older—will begin to increase dramatically, and even more quickly than the 65-to-84-year-old cohort (see Figures 1–6 and 1–7). Nationwide, the oldest old will increase by 56% from 1995 to 2010, and by almost 400% by 2050. The major increase for this age group occurs after 2030, when the baby boom generation begins turning 85.

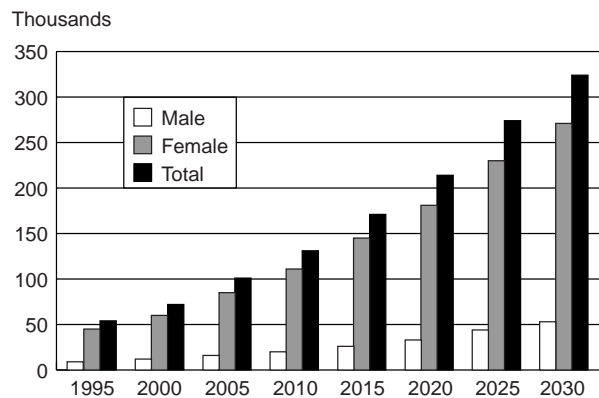
*Figure 1–6
California’s Growth in Numbers of the Oldest Old
(Age 85+)*



Source: State of California, Department of Finance

In California, the oldest old will increase from 383,000 in 1995 to nearly 1 million by 2020, and the numbers will grow even more steeply thereafter. The number of women within the oldest-old population in California will increase by 65% between 1990 and 2000, and women will account for 68% of the oldest old. This trend will continue through the first few decades of the 21st century; by 2010, the number of women within the oldest-old population will increase by an additional 77%.

*Figure 1–7
Centenarians in the United States, 1995–2030*

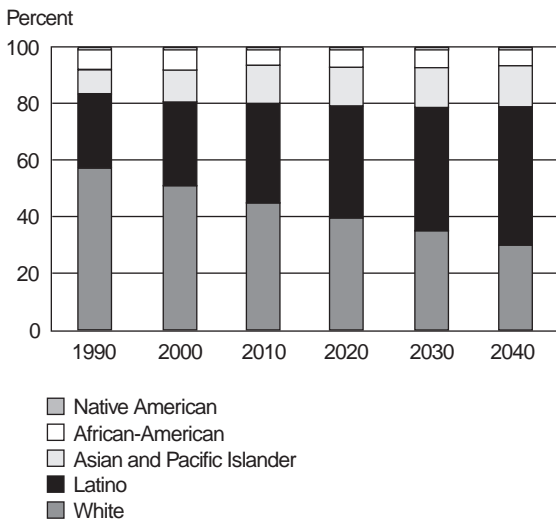


Source: U.S. Bureau of the Census. *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995–2050*. Current Population Reports, Series P-25, No. 1130. Washington, DC: USGPO, 1993.

More Diverse Younger and Older Populations

In the late 1990s, the state’s white population became a minority group for the first time since before the 1849 Gold Rush. During the next 40 years, Latinos will become the dominant group, accounting for 48% of the total population, and the white population will make up only 30% (see Figure 1–8). This trend toward more ethnic diversity is a national trend that California will experience much earlier than the nation as a whole.

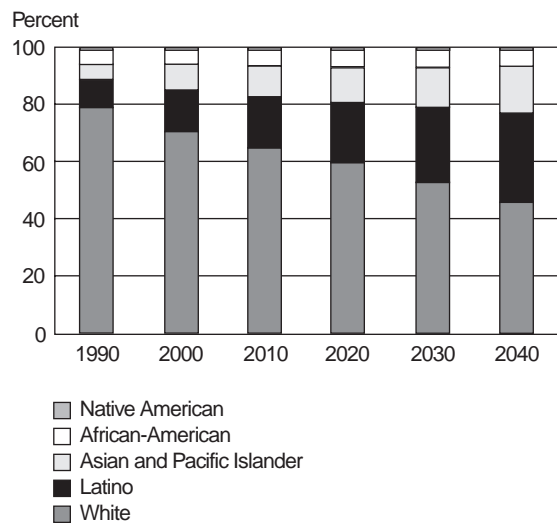
*Figure 1–8
The Changing Complexion of California, All Ages
(Relative size of ethnic groups in California, 1990–2040)*



Source: IFTF; State of California, Department of Finance.

At the same time that the size of the elderly population is increasing, its racial and ethnic composition is also changing. Currently, 27% of all Californians age 65 and older belong to ethnic or racial groups other than white; this share is expected to reach 35% by 2010 and 47% in 2030 (see Figure 1–9).

*Figure 1–9
California’s Older Population Is Growing More Diverse
(Relative size of 65+ ethnic groups in California, 1990–2040)*



Source: IFTF; State of California, Department of Finance.

THE CHANGING ROLE OF CALIFORNIA WOMEN

California may be at a turning point in terms of gender issues. During the last half of the 20th century, the state's women have made dramatic changes in how they live and work—especially those who entered adulthood in the late 1960s and women baby boomers. Through their investments in education, jobs, and technology, as well as by involving themselves in their own communities and California's political process, women are creating new identities and roles and making a greater impact on society. These women constitute the majority of college students, single heads of households, and educators. However, these women will face very different aging issues than the generation before them, when women were primarily homemakers and mothers. Older women in the future will demand to be more involved in decisions that affect their lives.

Women Are Major Contributors to Income

Women represent a growing proportion of the paid American workforce, regardless of age (see Table 1–1). In 1970, 43.3% of all women participated in the labor force. That figure will reach 61.4% for all women and above 75% for women between the ages of 20 and 54 by 2006. The participation rate for women has always remained below the participation rate of men for the labor force as a whole. By 2006, however, the gap will close to an approximate 6.2% difference, compared to a 17% difference in 1970.

Today, women contribute about 40% of all household income. Women generate \$3.3 trillion for the national economy and own one out of six businesses. Women also work longer hours than in the past. These are dramatic changes that have tremendous long-term consequences for the state.

Table 1–1
Labor Force Participation Rates for Women
(United States, 1970–2006)

	1970	1980	1990	1996	2006	Percent Change 1996–2006
Civilian Labor Force	60.4	63.8	66.5	66.8	67.6	0.8
Men (all)	79.7	77.4	76.4	74.9	73.6	-1.3
Women (all)	43.3	51.5	57.5	59.3	61.4	2.2
20–24	57.7	68.9	71.3	71.3	71.8	0.5
25–34	45.0	65.5	73.5	75.2	77.6	2.3
35–44	51.1	65.5	76.4	77.5	80.2	2.7
45–54	54.4	59.9	71.2	75.4	79.9	4.5
55–64	43.0	41.3	45.2	49.6	55.8	6.2
65+	9.7	8.1	8.6	8.6	8.7	0.1

Source: U.S. Census Bureau

Participation in the California workforce varies by ethnicity, but all groups of women are growing as a percentage of the workforce. Baby boomer women in particular will continue to exhibit strong labor force participation throughout their lives. The next generation, the so-called echo boom, born between 1977 and 1994, represent the next cohort of workers to watch. This generation will account for nearly one-third of the total state population, with more than 68% belonging to racial or ethnic groups (38% Latino). Women in this generation will also be diverse; 59% will be women of color, and they will enter the workforce in great numbers.

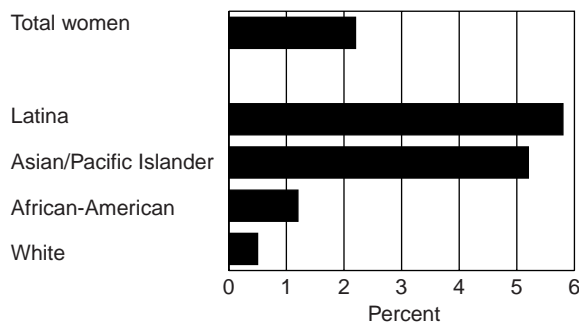
Historically, African-American women have had much higher work participation rates than white or Latino women, and they are still more inclined than whites to work full time. The work participation rates of Asian-

American women have grown faster than those of California women as a whole. While Latinas have lagged behind other groups in their labor force participation, they are now the fastest-growing group of working women in the state (see Figure 1-10). Within the next two decades, the composition of the workforce will change dramatically.

The Wage Gap Persists Despite Gains

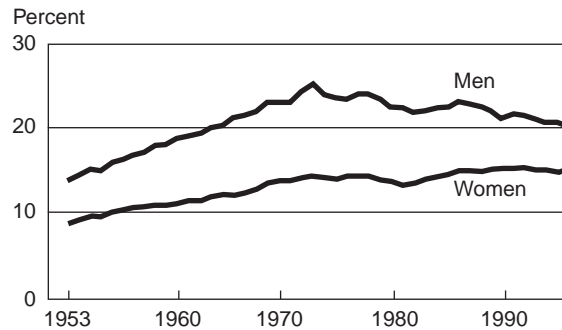
Women still earn only 73% of men's wages. Even though women are making some gains in closing the wage gap, this disparity remains a persistent problem. It stretches even wider for women of color (see Figure 1-11). Although the future of both the United States and California depends significantly on the labor of women, the historical earnings gap between men and women continues relatively unabated.

Figure 1-10
Participation by Women of Color Is Increasing in California's Labor Force
(Average annual growth in civilian labor force, 1990-1997)



Source: IFTF; State of California, Department of Finance, *Current Population Surveys*.

Figure 1-11
The Wage Gap Persists
(Median annual earnings for year-round, full-time workers, by sex, 1951-1996)

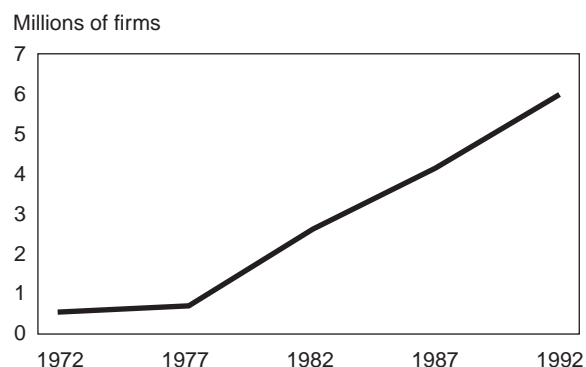


Source: U.S. Department of Labor, Women's Bureau.

**Women-Owned Businesses
Are Growing Fast**

Increasingly, women own businesses, and they constitute a driving force behind the current surge of economic growth and job creation. Between 1977 and 1992, the number of women-owned businesses expanded rapidly by 15% each year. In California, the number of women-owned business grew by 42% between 1992 and 1997. Women business owners now account for more than one-third of all businesses in the United States (see Figure 1–12). California’s women rank first across the nation in business formation, and California surpasses all other states in the number of women-owned businesses. In 1999, California women owned more than 1.2 million businesses, employing 3.8 million people and contributing \$549 billion to the state’s economy.

Figure 1–12
Number of Women-Owned Businesses, 1972–1992



Source: U.S. Department of Labor, Women’s Bureau, April 1999.

**Young Women Have Higher Levels of Educational
Attainment Than Men**

The role of women in California, largely defined by baby boomer women, will be further reinvented by younger cohorts. California women age 25 to 34 now exceed their male counterparts in both size and proportion of their age group’s educational attainment. More young California women (28.2%) than men (22.5%) have bachelor’s degrees or higher (see Table 1–2). In the coming decade, these women will exert their influence in the workplace as they pioneer new careers and roles for women in the community. Just as their predecessors did in the mid 1970s, they will transform the workplace by their sheer numbers and higher levels of education.

Table 1–2
Educational Attainment of California Women

Percent of age cohort with BA degree (age 25–34)

Women	28.2
Men	22.5

Highest degree attained (all ages)

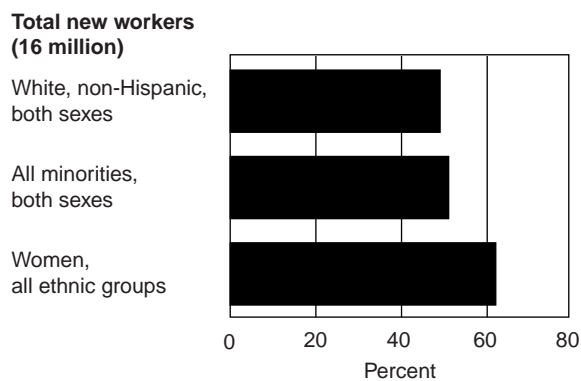
	Male	Female
Bachelor’s	49	51
Master’s	57	43
Professional/Doctorate	71	29

Source: IFTF; State of California, Department of Finance, *Current Population Survey*, 1998.

California Women Are Innovators in Work

Women are playing key roles in the major innovative industries of California, from the high-tech companies of Silicon Valley to the entertainment businesses of Southern California. Some of the biggest gains in the past decade have been in professions such as medical and health management, technical writing, purchasing, economics, financial management, and personnel labor management. Many of these fields are among the fastest-growing occupations, reflecting women’s unflagging commitment to pioneering new fields rather than adapting to traditional occupations. Nationwide, women will make up the majority of new workforce entrants between 1995 and 2005 (see Figure 1–13).

*Figure 1–13
New Workforce Entrants Will Be Women
(Percent of new workers, 1995–2005)*



Source: U.S. Department of Labor, 1997.

Women have also increased their share of employment in executive, administrative, and managerial occupations (see Table 1–3). Nationwide, the number of women in executive and managerial jobs increased 21% between 1975 and 1995. California’s women are increasingly filling these positions that require fundamental competencies in decision making, long-term thinking, team leadership, and visioning. These competencies have the potential to transform the social landscape of California, much as they changed the business landscape.

*Table 1–3
Women Are Gaining Ground in Management*

Occupation	Percent Women	Percent Change in Women’s Share of Employment (1975–1995)
Total workforce	46	7
Executive, administrative, managerial	43	21
Professional specialty	53	8
Technicians and related support	52	10
Sales and marketing	50	8
Administrative support and clerical	80	2

Source: Bureau of Labor Statistics, 1997.

California Women Are Techno Savvy

With more than 50% of households owning personal computers and 30% with access to the Internet, California leads the way among all states in household adoption and use of information and communication technologies. It is no surprise, then, that California women are sophisticated users of information and are increasingly comfortable online. Some 37% of women have access to the Internet either at home or outside the home and use e-mail for a variety of reasons, including for work and communication with friends and family (see Table 1–4). Women are now the fastest-growing group using online services and are driving the growth of e-commerce (online shopping and trading).

Women entrepreneurs are actively adopting the Internet and other new or growing technologies as tools for success. A recent survey of 800 women business owners nationwide found that they spent \$170 billion on

computer technology in 1997, up 60%. Another study showed that 47% of female business owners subscribe to online services, versus 41% of male business owners.

Driven by changes in their lifestyles, working women are pioneering ways of managing the complexities of work, home, and social life by using communications and information technologies. They employ the fruits of technology to extend their traditional home boundaries into a wider communication zone, as they integrate aspects of their highly mobile lives (using laptop computers, cell phones, personal digital assistants, e-mail, pagers, online services, and the like). They use technology tools to help balance their home and work life as well as to carve out more time to spend with their children or even elderly dependent parents. These skills will enable them to continue to be innovative and good managers (as well as good consumers) as they age.

Table 1–4
California Women Are Technology Users
(Percent)

Access to Internet	
At home	21
Outside home	16
Any location	37
Use e-mail for ...	
Communicate with family and friends	92
Job-related	39
Hobbies/special interest	34
Educational	29

Source: National Telecommunications and Information Administration, U.S. Department of Commerce, *Falling Through the Net: Defining the Digital Divide*, 1999.

“In many ways, aging policy is a woman’s issue. This is because, in every measure, women are in the majority in the elderly population, and their numbers increase in proportion as the population ages. Mid-life and older women are the most likely caregivers of older disabled parents, spouses, and other relatives.”

—Deborah Reidy Kelch,
The Health of Older Women in California

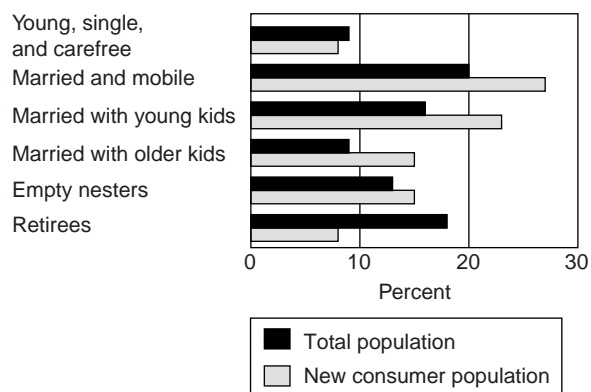
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**CALIFORNIA'S OLDER NEW CONSUMER:
SOPHISTICATED AND SAVVY**

California has increasing numbers of both wealthy and poor elders—both of which are creating fault lines in the state’s landscape. Consumer preferences among elderly Californians are moving in new directions as they change their lifestyles to live longer and healthier lives. This vibrant group of elders, who account for about 30% of all Californians 65 and older will grow—accompanied by higher levels of income and educational attainment, and increasing use of technology—and so will their influence on the marketplace.

Recent research by IFTF on the new consumer across life stages demonstrates conclusively that people who have some college education and discretionary income, and who adopt information technologies, are very different kinds of consumers—and they are transforming the marketplace. New consumers behave differently than traditional consumers by demanding more choice, control, convenience, and service. Their power has become so great that they now drive economic growth in both the United States and the European Community. A substantial number of new consumers are already in the current 65+ group, and that share will continue to grow as the baby boomers age (see Figure 1–14).

*Figure 1–14
New Consumers Across Life Stages*

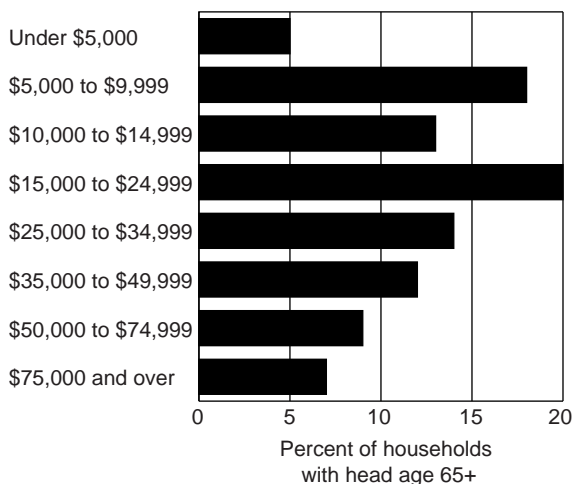


Source: IFTF; Corporate Associates Program, Brands Survey, 1998.

Average Income Among Older Californians Is High

In California, the average income of older persons has increased at a faster rate than that of other age groups, while poverty among California’s elders, at 7.6%, is less prevalent than among the total population. Although there are pockets of poverty, the economic situation of the elderly has improved over the past several decades, with more 65+ households in middle- or high-income brackets (see Figure 1–15). Median adjusted family income for families headed by a person 65 and older has grown by 25% since 1973 whereas incomes in families headed by someone 35 and younger declined by as much as 10% in that period.

*Figure 1–15
More California Households Headed by Someone 65+
Have Middle or High Incomes
(Distribution by income)*



Source: U.S. Census Bureau.

Increasing Levels of Education

Among the elders, high educational attainment levels are increasing both nationwide and statewide, resulting in a group of older Californians who are better educated than their predecessors. This trend will increase significantly in the coming decades, as younger, more educated cohorts approach retirement age, and will impact the types of services and products demanded by older adults (see Table 1–5).

*Table 1–5
Educational Attainment, California, 1998
(Percent of age group with bachelor’s degree)*

	<i>Total</i>	<i>Males</i>	<i>Females</i>
35–49	28.8	31.2	26.5
50–64	29.3	32.6	26.3
65+	18.8	24.4	14.2

Source: State of California, Department of Finance, 1999.

California Seniors Are Online

An increasing number of older Californians are going online, through personal computers at home and Internet appliances; some even venture online from the comfort of their recreational vehicles as they travel around the country, or stay in “wired” motels or elder hostels. Of the estimated 78 million Internet users in the United States, 13 million (16.5%) are adults over the age of 50, and that number is expected to nearly double within the first decade of the 21st century. Baby boomers are behind this growth, and as they age, the number of people over 50 will increase. Every eight seconds a baby boomer is turning 50, and the 50+ market represents more than \$1.6 trillion in buying power.

Even people 65 and older are going online. A recent survey by the American Association of Retired Persons (AARP) found that elders are using the Internet to pursue personal interests, communicate with family and friends, widen their social circle, and improve the quality of their lives. Although the proportion of adults aged 55 and over with Internet access is low compared to other age cohorts, baby boomers will increase that number over the next decade (see Table 1–6).

*Table 1–6
Baby Boomers Will Increase the Number of Elders
Online
(Percent using the Internet, by age and location, 1998)*

	<i>At Home</i>	<i>Outside Home</i>	<i>Any Location</i>
Boomers			
35–44 years	29.1	20.0	39.8
45–54 years	28.6	18.8	38.7
Elders			
55+ years	11.0	5.5	14.4

Source: National Telecommunications and Information Administration (NTIA) and U.S. Census Bureau, U.S. Department of Commerce, using *Current Population Surveys*, December 1998.

LOW SAVINGS AND INADEQUATE RETIREMENT INCOME

Low macro statistics for poverty hide the troubling poverty into which the state's vulnerable elders may be at risk of sliding. If we view the growing numbers of elderly as a tidal wave, we must also look at the dangerous fault line that will contribute to this economic disaster of elderly living in poverty. We must ask: What happens if the economy shrinks even as the population expands? Who will pay for those two "extra" decades, as Californians increasingly live not just to roughly 80 years old but sometimes to 100 or more? And what will happen to the persistent underclass within the baby boom generation that will age along with their wealthier counterparts?

Most Americans hope to enjoy an undiminished standard of living in retirement, but many Californians are not saving enough, and may have to work well past 65 to meet their own needs. This is particularly true for ethnic minorities. Retired people rely on four main sources of income—part-time employment, government benefits, private pension income, and personal savings—and each has an uncertain future.

Dramatic Shifts in Sources of Income for Retirement Years

Although retirement income sources will remain the same, there will be a dramatic shift in the percent of funds available from each source. This shift will occur for many reasons, ranging from the decrease in employer-based pension funds to shrinking Social Security and federal health funds (see Table 1–7). This shift will have negative consequences for the elderly with low incomes, who tend to save less, have little or no accumulated wealth, and do not have pension income to rely on.

Table 1–7
More Retirement Income Will Come from Work
(Percent of retirement income from each source)

	1992	2029
Traditional Pension		
Employer paternalism fades and old-style pensions fall	8	4
Federal Income		
Social Security and Medicare benefits reduced	19	7
Work Income		
Work income increases as Social Security and pension income declines	27	41
Investment Income		
Total income from investments holds steadily, but the 401(k) component rises as responsibility shifts to employees	46	48

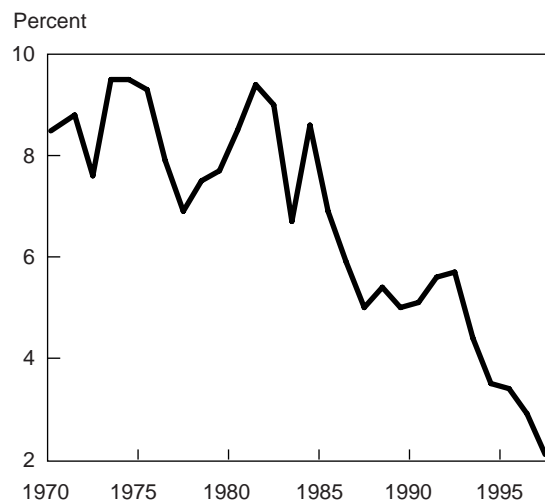
Source: *Fortune*, 1996.

**Historically Low Levels of Savings
Are Falling to New Lows**

By any standard, most Americans do not save enough, and retirement saving—for certain groups—is especially inadequate. Savings as a share of disposable income has fluctuated since 1975, but a downward trend remains in place (see Figure 1–16). Determining whether the elderly will have enough resources in retirement is not a straightforward task given improvements in longevity and uncertainties regarding public policy on Social Security and Medicare.

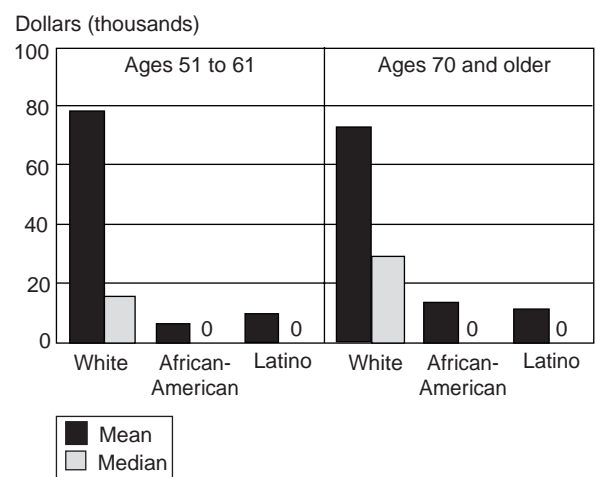
There is significant concern that a large portion of California’s population is not saving enough for retirement, particularly ethnic groups and women. In 1992, 43% of families in the United States spent more than their income; only 30% accumulated assets for long-term savings. U.S. Census data in 1990 showed that half of all families had less than \$1,000 in net financial assets, a figure that has not increased over the past decade. Even among adults in their late 50s, one-third are expected neither to accumulate sufficient financial assets to retire in adequate comfort nor to receive a private pension. This trend is particularly extreme for African-American and Latino elderly (see Figure 1–17).

*Figure 1–16
Americans Do Not Save
(Saving as a percent of personal disposable income)*



Source: Economic Report of the President, 1999.

*Figure 1–17
Household Wealth, by Race and Ethnicity*



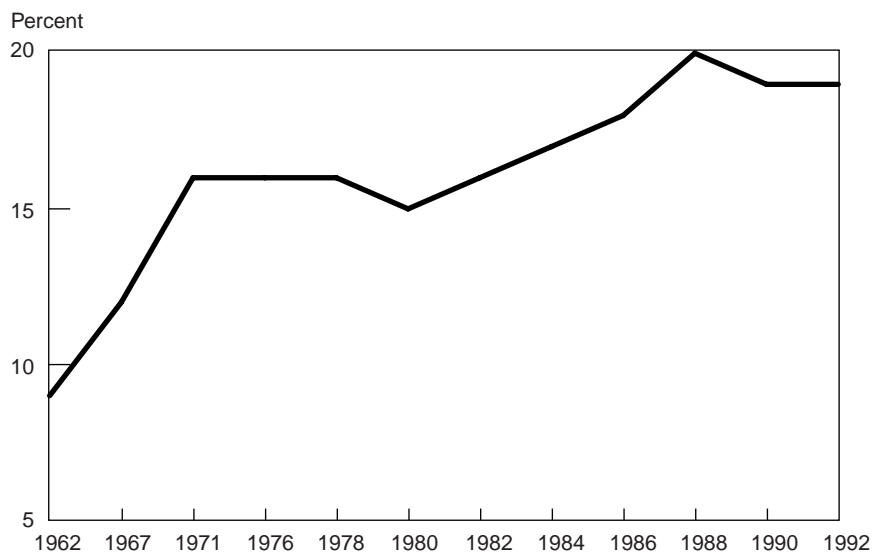
Source: Economic Report of the President, 1999.

Pensions Are Becoming More Important Sources of Income, But Benefits Are Small

The proportion of elderly who receive pension income has doubled since 1962 (see Figure 1–18), and pensions account for 19% of retirement income. Furthermore, the responsibility of individuals for financing and managing retirement is increasing with the shift from defined-benefit to defined-contribution pension plans. This is particularly true in California, where businesses have introduced innovative work environments, moving from traditional large corporations to networked organizations, flexible workforce staffing, shared jobs, and great numbers of small businesses and sole proprietorships. Even traditional companies are cutting back on their defined-benefit plans—a fixed payout based

on a formula derived from salary and years of service—moving toward defined-contribution pension programs such as 401(k) plans, in which employees choose the investment options and bear all the risks. As a percent of all private pension plans, defined-contribution plans increased from 67% in 1975 to 88% in 1993. But workers may not be taking sufficient advantage of these retirement savings plans. Furthermore, as more workers make their own investment decisions, poor or too-conservative choices could lower their retirement living standards. There is a lack of education and information regarding retirement investing; few people know how to do it.

*Figure 1–18
Pensions as a Proportion of Retirement Income*



Note: Includes private pensions and annuities, government employee pensions, Railroad Retirement, and IRA, Keogh, and 401(k) payments.

Source: Social Security Administration, Office of Research, Evaluation, and Statistics, *Income of the Aged Charbook*, 1996, 1998.

California's Retirement Benefits Are Further Complicated by a High Rate of Uninsured Working Californians

The Golden State has the highest rate of working people who lack health insurance of any of the 50 states (see Table 1–8). Approximately, 84 % of the 7 million uninsured Californians work full time, part time, or are self-employed. In today's economic context, this seems counterintuitive because, in the past, as the nation experienced periods of economic growth, the number of uninsured typically declined. Now, however, while California and the nation are experiencing one of the longest sustained periods of economic growth in history, the number of people without health insurance is actually increasing. One fundamental shift is behind this trend—

the shift from defined benefits to defined contribution, which increasingly makes health insurance unaffordable. Employers are cutting their costs in this area by shifting more of the financial responsibility to employees, cutting dependent benefits, and eliminating choice in health plans. As health care premiums increase (some 10% to 12% in 1999 alone), fewer workers can afford health insurance for themselves and their families. Eventually, employers will shift from defined benefits to defined contributions toward a health insurance premium, making the costs to the employee unaffordable. As a result, fewer Californians will enjoy employer-sponsored health care benefits in their retirement years.

*Table 1–8
The Ranks of the Uninsured in California Are Growing
(Uninsured, age 0 to 64, by family work status, 1995)*

	<i>Work Status of Primary Adult</i>				
	<i>Full-Time Full-Year Employee</i>	<i>Full-Time Part-Year Employee</i>	<i>Part-Time Employee</i>	<i>Self-Employed Worker</i>	<i>Nonworker</i>
Uninsured Rate	18%	34%	30%	35%	26%
Percent Distribution	48%	16%	12%	8%	15%
Number of Uninsured	3,369,000	1,123,900	842,400	487,000	955,000

Source: UCLA Center for Health Policy Research, The State of Health Insurance in California; *Current Population Survey*, March 1998.

Entitlements Are Under Severe Pressure

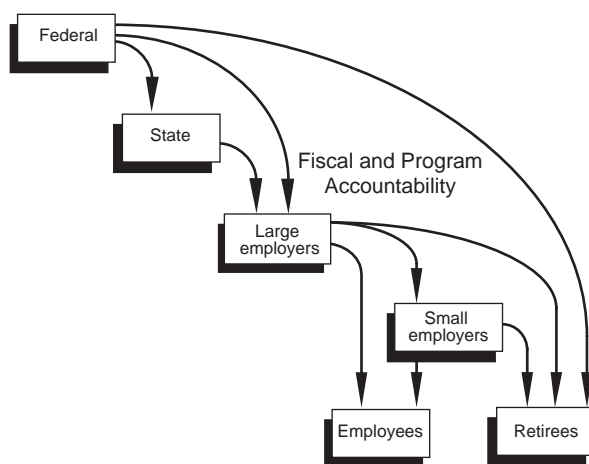
In an age of budget cutting, large federal entitlement programs—developed during the 1930s and continued through the 1960s—invite heightened scrutiny from legislators wielding budget-trimming axes. Programs to which Americans feel entitled, such as Medicare, Social Security, and Medicaid are prime examples. Politically and fiscally, these entitlements will remain areas of intense conflict, despite cross-generational support for the elderly, and despite the high electoral participation the elderly have always demonstrated.

The recent policy decision to raise to 67 the age at which Social Security kicks in, combined with anticipated Medicare trust fund deficits looming from 2000 to 2010, means more costs will be passed on to the elderly and retirement will be delayed as more people will work beyond the age of 65.

Devolution: Federal Government Pushes Decision Making and Responsibility to States, Local Government, and Individuals

The role of the federal government in health care and social welfare is changing dramatically. Although the federal government is maintaining Medicare and Social Security, it is passing on, or devolving, more financial and programmatic accountability to policymakers at state and local levels, and to employers without infrastructure buildup. Devolution, by definition, gets into local politics. Although intentions may be noble, the devil is in the details. It is much easier to address elder needs at the federal level. Such shifts cause huge political and economic pressures at the state and local level, while forcing individuals to take more responsibility for their own health and well-being, even if they are accustomed to expect help from federal entitlement programs such as Social Security and Medicare (see Figure 1–19).

Figure 1–19
The Elder Care Cascade

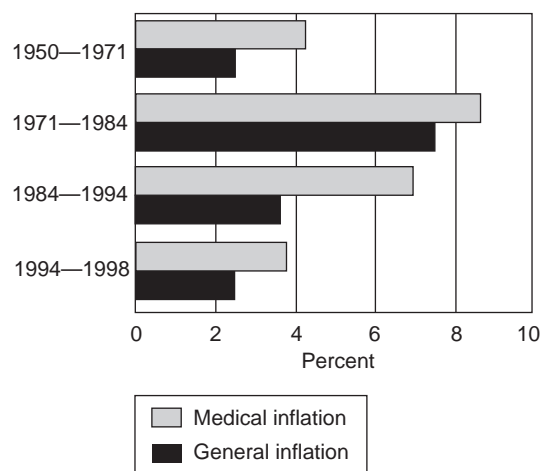


Source: IFTF

THE CONTINUING INCREASE IN HEALTH CARE COSTS

Controlling health care costs will remain a challenge, particularly for the elderly (and their adult children). True, the high health care inflation rates of earlier decades have come down to more moderate levels in recent years, due in part to the rise of managed care. However, overall health care costs, both in absolute and relative terms, will continue to increase steeply, possibly at as much as double the rate of overall inflation (see Figure 1–20).

Figure 1–20
Medical Inflation Has Outpaced General Inflation



Source: IFTF; Economic Report of the President.

Cost Drivers Remain the Same

At present, the huge variety of factors that contribute to high health care costs include low productivity, system fragmentation, excess hospital and physician capacity, growing numbers of uninsured and underinsured patients, increases in the size of the elderly population, high demand for new technologies, and the cultural propensity of Americans to spend a large share of income on health care. Many of these cost drivers will persist into the next decade. Indeed, total health care spending in California is projected to rise from \$186.3 billion in 2000 to \$255.1 billion by 2004, for an average increase of 8.2% per year (see Table 1–9).

Table 1–9
 Source of Funds for California Health Care Costs
 (By calendar year, in billions of dollars)

<i>Funding by Source</i>	1996	2000	2004
<i>Households</i>			
Household insurance premium payments	\$12.5	\$17.1	\$23.4
Out-of-pocket spending	22.9	28.4	35.2
Other household spending	5.1	6.9	9.3
Subtotal	40.5	52.5	67.9
<i>Private Employers</i>			
Contributions for employees' health insurance	28.5	39.2	53.9
Other employer spending	4.0	5.5	7.6
Subtotal	32.5	44.6	61.5
<i>State and Local Government</i>			
Contributions for employees' health insurance	8.8	12.0	16.4
Medicaid (state)	10.0	15.1	22.8
Other state and local spending	6.2	7.1	8.1
Subtotal	24.9	34.2	47.3
<i>Federal Government</i>			
Contributions for employees' health insurance	1.8	2.4	3.2
Medicaid (federal)	10.2	15.5	23.6
Medicare	21.6	31.2	45.1
Other federal spending	5.1	5.8	6.6
Subtotal	38.7	55.0	78.4
Total California health care costs	\$136.6	\$186.3	\$255.1

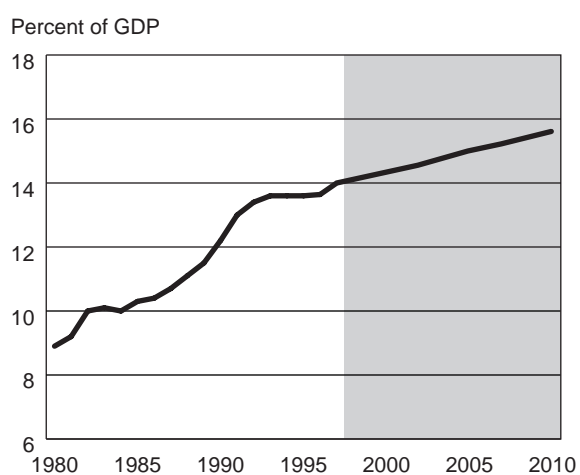
Note: Detail may not add to total, because of rounding.

Source: IFTF; Barents Group, LLP of KPMG, *California Health Modeling System*.

National Health Expenditures Will Grow

Health care costs will likely continue to grow. National health expenditures (NHE) are just under 14% of gross domestic product (GDP) and are expected to grow at 6.5% per year. By 2005, NHE will account for 15% of GDP, heading toward 16% by 2010 (see Figure 1–21). And with health premiums expected to increase as much as 12% in 1999, cost containment remains one of the most fundamental forces of change. Two important factors that will affect cost growth are the cost burden of chronic disease and the cost of medical technology. Although the incidence of disease is relatively steady, the cost of controlling disability within an aging population is increasing. Nationwide, direct medical costs for the treatment of chronic disease and illness exceed \$500 billion annually and account for 45% of NHE. And our health care system's intense use of medical technologies and advanced pharmaceuticals is now responsible for approximately 50% of the annual growth in per capita health care expenditures.

Figure 1–21
Projection of Future Health Care Spending
(Health care expenditures as a percent of GDP)



Source: IFTF

6

NEW INFORMATION AND
MEDICAL TECHNOLOGIES

“If we can be socially inventive enough to overcome this ‘digital divide,’ then older people around the world may be among the first to benefit from access to computers. I’d like to challenge every young person to reach out to a parent, grandparent, or neighbor, and share with them the possibilities that the computer and the Internet make possible. I think they would be surprised by the results.”

—Julia T. Alvarez, 72, Chair of the United Nations International Year of Older Persons 1999 and an Ambassador on Aging

The possibilities that information technology, the Internet, and new medical technologies will allow are already having a revolutionary impact on society—perhaps to a greater degree in California, where many of these advances originated. And for once, the information revolution isn’t passing by the older population. Older citizens are joining the ranks of information and communications technology users and stand to improve their quality of life, both social and physical, because of it.

Information and Communications Technologies

Over the next decade, the lives of older people are likely to be significantly impacted by new technologies. The revolution in communication and information technologies is beginning to have an effect on elders in both their health management and their social life. Information technologies could address these unmet needs:

- *Staying connected to family and friends.* The global economy means mobility. Children move away from home, driven by new or better opportunities in distant locations. Elders need a way to stay in touch and continue to feel part of a family.
- *Maintaining and managing income.* Sixty-five isn’t old anymore, and older workers will become common—and will enjoy supplemental incomes. Elders won’t rely on Social Security as much as other, multiple sources for individual retirement income. Information technology can help them manage assets wisely.
- *Shopping for essential goods when homebound.* Frail elders won’t be able to go to the mall. Some of their basic needs will be met in other ways. Online services can deliver food, pharmacy supplies, and laundry, and fill other regular needs.

- *Accessing medical and health care.* Health care services are moving out of the hospital and into the home and community. Disabilities and health problems that only a decade ago would be treated in a hospital setting are being managed outside of traditional health care facilities. Therefore, the burden of managing care now falls on the patient and the family. Some health care consumers will embrace the opportunity for increased involvement in their health care and medical treatment.
- *Managing safety and security.* Both in and out of the home, elders need to be safe and secure. They need to alert others when they're threatened by burglars, acute medical problems, or even home appliance malfunctions.
- *Having fun.* Getting out of the home for entertainment and fun can be difficult for older people, who need social stimulation to maintain quality of life. Could a new set of interactive games geared to older folks be both profitable to distributors and beneficial to stay-at-homes? The possibilities are endless.

**Bandwidth to Burn:
Using the Pipe for Telehealth**

The United States has been the bellwether country in the use of information and communications technology—in industry and in the household—but has lagged in applying them to health care. Expect more in telehealth innovations for elders over the next ten years, and watch to see if Medicare continues to reimburse providers for some telehealth.

Three main trends will converge in the use of interconnecting technologies.

- *Remote care management.* Future case management will be remote-care case management. It will concentrate on chronic disease states and clinical protocols that assess appropriate treatment of specific conditions and clinical

data collected from individual patients. Nonphysician care managers will use these systems to improve treatment options. Call centers will help deliver information to patients, increasing self-management.

- *Telehealth.* Telehealth applications are going on now in dermatology and radiology. However, there is a lot of hype. Not much of medical care lends itself to telehealth.
- *Patient-information systems.* The same technologies that support case management will be used by patients to access a variety of health information services through the Internet, including online libraries, interactive voice response, and video-on-demand, among others.
- *Remote telemetry.* Sensors will enable a revolution in remote care, providing the capacity for remote telemetry. Soon, sensor technology will be cheap enough to drive adoptions in medical devices such as wireless heart monitors and respiratory meters, monitors for blood sugar levels, and alerts from pill dispensers when medications aren't taken as prescribed. Ultimately, two-way video will allow consultations to take place in the home.

**Impact of the Internet:
Older-Consumer Health Information and Support**

The Internet will have many impacts on health care for elders, and uses of the Internet that are designed to appeal to older consumers will expand greatly over the next ten years. The elderly increasingly will use the Internet both to seek information about health and health care and to create communities and support groups. These two areas will be particularly important for older online users.

- *Health information on the Web.* Online consumers will seek information from the thousands of Web sites dedicated to health and health care. The number of health care

Web sites will proliferate, as established health care organizations, new Web-oriented health start-ups, and interested individuals post their content to these online repositories, which are open and free to anyone with Internet access. A number of approaches, including ratings services and trusted brands, will help consumers sort through the clutter of competing sites and advertising hype. Online purchases of both prescription drugs and over-the-counter items will also increase during the next ten years.

- *Online support groups.* Support groups will continue to grow rapidly as online resources for patients with a given disease and the people who care for them. Patients participating in such online groups will feel more in control, and those with particular diseases will experience better outcomes. There will be points of strain, however, between patients and some physicians who feel loss of control over patients' care or fear their authority will be threatened by more-educated, well-read patients who have stopped being passive consumers of medical care. Physicians are also worried about the danger of misinformation online.

Medical Technologies

Rapid advances in medical technologies will provide new options in medical care and chronic disease management. Eight medical technologies, to cite only recent developments, will make a huge difference in health care over the next ten years; most of them have implications for the care of older Californians.

- *Rational drug design.* This differs from traditional drug research because researchers develop rather than just discover chemical or molecular entities. They look at the physical structure and chemical composition of the target (such as a molecular receptor or enzyme). Re-

searchers then design drugs that bind only to these specific sites, turning the targets on or off, thus halting disease mechanisms. Scientists identify the qualities of the specific agent that creates the pathology and then design drugs to intervene. Rational drug design will impact a number of medical challenges, particularly neurologic and mental diseases, antiviral therapies, and the development of new antibiotics.

- *Medical imaging.* Advances in fundamental technologies, such as energy sources and detectors, image analysis, and visual displays, are combining to create several new imaging technologies such as electron beam computed tomography, harmonic imaging (which improves on ultrasound), functional imaging (allowing metabolic imaging, not just structural), and image-guided surgery. These advances will improve the diagnostic process immensely and in some cases even help patients avoid surgery. They will also decrease the need for invasive diagnostic procedures before surgery.

- *Minimally invasive surgery.* Technological advances in fiber optics, miniaturization of instruments and devices, image digitization, and navigational systems for vascular catheters will continue to mitigate the risks posed by surgery, change some procedures to simple outpatient tasks, and reduce mortality.

- *Genetic mapping and testing.* Clinical genetics has moved from mapping the causes of single diseases to extensive profiling of more complex and late-onset diseases such as cancer, Alzheimer's disease, diabetes, and heart disease. The downside in such genetic understanding is that some diseases can be mapped genetically but still cannot be treated clinically.

- *Gene therapy.* New *in vivo* approaches (inside the body) with viral or nonviral vectors or DNA are now

being administered to patients. Clinical trials are in progress for various cancers, genetic diseases, and pathological signs such as hypercholesterolemia. Despite enormous progress, application of such gene therapies will likely be slow over the next decade.

- *Vaccines.* Molecular biology, molecular medicine, and recombinant DNA technology are moving vaccines out of the laboratory and into actual preventive and therapeutic uses. Anticancer vaccines, to give just one example, are gaining increasing attention.
- *Xenotransplantation.* Current research in xenotransplantation (the relocation of cells, tissues, and whole organs from one species to another) focuses on pigs, which are quite similar biologically to humans. Currently, such pig transplants serve as temporary bridges while physicians wait for human transplants to become available. Soon, so-called “transgenic” pigs will be available

for permanent replacement parts. The potential is inspiring, though society will find daunting the public policy and ethical issues around allocating such resources without regard to class, power, or wealth.

These and other medical technologies, and the deciphering of the human genome, will provide many more options regarding people’s health and health care in the future, within California and around the nation. Advances in biotechnology will increase knowledge about the life cycle and causes of a battery of diseases. Ultimately, these advances will increase our ability to diagnose, manage, and treat diseases well before their costly and disabling effects surface. For our aging population, these medical technologies—if they can be accessed equitably and if they are affordable—will ultimately sustain life and improve the overall quality of life for many.

FACING THE FAULT LINES

As the six drivers shake California’s foundations in the next decade—and as older Californians scan the horizon with hope or fear—those who analyze and affect social policy must keep their eyes fixed squarely on the fault lines of change. The ground under the Golden State is constantly shifting—usually imperceptibly, but sometimes massively with widespread implications—and so too are social and economic forces that impact the lives of all Californians, particularly the elderly.

Intersections

DRIVERS AND CRITICAL ISSUES TO 2010

The six fault lines of change described in Chapter 1 will slowly shift the demographic and socioeconomic landscape of California. The pace of change will continue steadily until 2010 and then pick up over the next 40 years. During this upheaval, many critical issues will emerge.

The following pages describe nine critical issues, first in chart form, showing their intersections with the six drivers over the next ten years, and then in more detail.

Drivers	Critical Issues
<ul style="list-style-type: none"> • The Aging Population and Its Growing Diversity • The Changing Role of California Women • California's Older New Consumer: Sophisticated and Savvy • Low Savings and Inadequate Retirement Income • The Continuing Increase in Health Care Costs • New Information and Medical Technologies 	<ul style="list-style-type: none"> • The New Pioneers: 80-to-100-Year-Old Californians • The Haves and the Have-Nots: Growing Polarization Among the Elderly • California's Ethnically Diverse Older Population: The Rich Legacy of Many Cultures • The Growing Vulnerability of Older Women • Elder Medical Care: Fragmentation of Financing, Programs, and Services • The Housing Challenge: A Growing Need for Senior Housing and Community-Based Services • The Caregiver's Conundrum • California's Aging Workforce: Challenges and Opportunities • California Community Readiness: Regional Maldistribution of Resources

The Aging Population and Its Growing Diversity

Changing Role of Women

Older New Consumers: Sophisticated and Savvy

Oldest Old

- The 65+ population increases; California will have more people 65+ than any other state
- The fastest-growing group is the 80+ cohort, and most are women
- A new definition of “old” emerges as 80+ elders demonstrate successful, healthy aging
- Most of the oldest old live in Southern California

- Working baby boomer daughters and daughters-in-law are the primary caretakers of the oldest old
- Ethnic women, especially Latinas, are working in increasing numbers; this decreases their time to care for the oldest old
- Look for signs that baby boomer women take up the cause of the oldest old at all levels

- Few oldest old are new consumers, but as their numbers grow, the wealthy 65+ population adopts more successful aging practices
- A side benefit of the demands of older new consumers will be new products and services that support long life for everyone

Haves/Have-Nots

- White, Japanese-American, and Chinese-American elders are healthier, wealthier, and live longer
- Gender and race matter a lot; most of California’s elder have-nots are African Americans, Native Americans, Latinas, or women
- More than 55% of California’s African-American elders live below the poverty line
- Income disparity will increase as both high-income households and elders in poverty grow

- More California women enter the workforce and are major contributors to household income, bringing prosperity to upper-income households
- Married white women continue to be the haves; ethnic women, particularly African-American women, are the have-nots
- Baby boomer women are more educated and will avoid poverty
- More women have pensions
- Most older African-American women are poor

- Older new consumers represent 35% of elders by 2010
- Numbers of high-income older households will increase
- Large older niche market begins to grow from 2000 to 2010; increasingly health-conscious haves drive new market
- The niche market for health goods for women is strong in the long term, but little will happen in the next decade
- Political clout of wealthy elders grows; they will demand better public policy

Ethnic Elders

- The Asian elder population will have the fastest growth rate until 2010, when the Latino elder population will grow the fastest, for several decades
- Minority elders, despite their increase in numbers, remain invisible to Californians outside their own communities
- Older immigrants will live longer and age in place; most live in Southern California
- Native Americans are small in number but are long-lived

- Elder women of color live with or are cared for by daughters and daughters-in-law
- African-American older women live alone
- There are few well-educated ethnic older women
- Few older Latinas have worked, but that begins to change
- Social networks in neighborhoods will become more extensive

- Although the numbers are small now, Latinos will have a cohort of new consumers who will drive the development of a new niche ethnic market that will be very large in the long term
- Asians, particularly Chinese Americans and Japanese Americans, will dominate the ethnic new consumer cohort

Low Savings and Inadequate Retirement Income

- Most elders did not expect to live to be 80+, and are not prepared
- Look for poverty rates to increase for California's 80+ population
- Social Security will be the major income source when savings and pensions run out for many in their 70s

- More middle-income elders will slide into poverty with longer life, especially those who live beyond 75; decreasing employment-based pensions and retirement health benefits hurt more the longer you live
- Young widows from middle-income households slide into poverty as they lose benefits when their husbands die
- Change in entitlements hurt have-nots the most

- Work histories are fragmented, and few elders will have pensions
- The vast majority of elders will have poor educational backgrounds; they will find it hard to supplement their income
- Most ethnic baby boomers have low savings and inadequate retirement income

Increasing Health Care Costs

- High medical costs drive into poverty the oldest old, who need more drugs and services; few have income levels that can absorb out-of-pocket costs
- New ethical challenges surface regarding who gets care and how much can be put into the care of the oldest old
- New drugs and technologies account for 50% of the increase in per capita costs

- More out-of-pocket health care costs drive more poverty; middle-income elders are at increasing risk of sliding into poverty
- Medical HMOs attract mainly lower-income elders who can't afford drugs not covered by other plans
- Poor elders postpone medical care; there is an increase in morbidity from poorly managed chronic diseases

- There are many cultural barriers to the formal health care system for low-income ethnic elders; these barriers prevent them from getting the most out of their Medicare benefit
- Watch for a move to non-Western practices to manage health and illness in old age

New Information and Medical Technologies

- New technologies decrease the risk of interventions
- Wearable devices communicate data continuously to doctors
- Cell phones maintain connectivity to families
- Aware environments increase safety and security
- Oldest old may be denied new technology because of age ethics

- Copays are not affordable by all
- Haves are more tech savvy and tech literate
- Price is a barrier for new information and communications devices
- Look for kiosks for information in senior centers and low-income housing

- Technology is rarely part of the health culture
- More alternative medicines and practices will be used
- Ethnic health-oriented television will become a channel for medical information

The Aging Population and Its Growing Diversity

Changing Role of Women

Older New Consumers: Sophisticated and Savvy

Vulnerable Older Women

- In many ways, aging is a women's issue; California women outlive men by seven to ten years
- Most older California women are white and single, a trend that will persist for several decades
- African-American women are long-lived and single
- Women suffer increasingly more disability than men as they live into their 80s and 90s

- Older women will become recognized as the most vulnerable older group, but little will be done to address their needs in any way
- Baby boomer women are less vulnerable—more elder women are college-educated, compared to current older women in California, because of the education levels of baby boomers

- There will be few vulnerable older new consumers
- As women become more educated, they will use their skills to manage their vulnerability

Fragmented Medical Care

- Demand for long-term care begins to build and explodes after 2010, when the baby boomers turn 65
- A successful aging health industry booms as the growing numbers of California's elders become more health conscious and look outside the formal system for ways to enjoy long life
- The critical need for physicians and other professionals with geriatric skills grows as the provider-to-older person ratio increases to an unsustainable level

- Working women are challenged to coordinate fragmented services for their aging parents
- Women politicians push for policy to integrate services and focus on nursing home and long-term care
- Look for growth of women-owned businesses that coordinate and manage care of elders

- Growing numbers of older new consumers demand more continuity, coordination, and information
- Increasing numbers of older new consumers will have private long-term care insurance, but policies will cover less than 20% of needed services
- Older new consumers will use their disposable income to seek services beyond traditional Western medicine and outside the formal health system

Housing

- Look for an increase in four-generation households as a housing strategy, especially among lower-income populations
- There is an increased demand for home modification as people want to age in place in their own homes
- Women are the dominant group in low-income public housing, as they become widowed and frail

- Older women experiment with new housing arrangements; look for more shared housing, elder-run "bed-and-board" facilities
- Middle-age baby boomer women increasingly manage two households: their own and their parents'
- Women politicians push for more low-income housing for the growing group of low-income women elders

- Most older new consumers will own their own homes and be able to support their own aging in place
- This will be the group that buys into high-end retirement communities
- Baby boomer new consumers in their 50s will build mother-in-law units and buy portable units for 75- and 85-year-old parents

Low Savings and Inadequate Retirement Income

- Most older women will depend on their husband's pension, which they will lose when he dies
- Few older women will have job pensions, because most held low-paying jobs
- Few older women will have private health insurance, either that they pay for themselves or that come from retirement health plans

Increasing Health Care Costs

- Larger numbers of elders in the system drive costs up because they need more services
- Older women postpone health care
- Out-of-pocket costs drive increasing poverty
- Elders are unable to purchase care services such as meals or assisted living

New Information and Medical Technologies

- Due to ageism, many elders will not be offered new technologies
- Many elders will not be tech savvy—and will not take advantage of low-cost technologies
- Price can be a barrier
- Telephones will remain primary tools

- Decreases in private medical insurance for older people means health care consumes a lot of income
- There is a growing mismatch between services needed and services covered by Medicare; paying for noncovered services will take an increasing amount of income

- Health care costs continue to outpace inflation
- Copays increase in number and amount to offset provider's rising costs
- Elders consume more health care
- Elders will have a larger number of prescriptions
- Medicare reforms include prescription benefit before 2005
- New technologies drive new services
- Quality problems continue in nursing homes

- Technology will drive up costs
- Watch for new experiments in telehealth
- Increase in disease management will contribute to fragmentation
- In the long term, new technologies will increase coordination, but health care will continue to be slow to install technology
- Elders will go online for medical alternatives
- Information technologies will not help integration, only access

- Middle-income elders who live longer have to tap into home equity for day-to-day living expenses or for emergencies
- Housing costs will rise above 50% of income for low-income elders

- Elders refinance homes and opt for reverse mortgages to pay for health care
- High-end elder communities will become more expensive as they add health and medical services
- Government moves away from providing housing for elders as medical and health components add expenses

- New technologies improve housing so elders can live and age in place more readily and affordably
- Community local networks provide security and alerts
- Networks in local housing units are linked into the local hospital and other services; home care monitoring

The Aging Population and Its Growing Diversity

Changing Role of Women

Older New Consumers: Sophisticated and Savvy

Caregivers

- Aging brings an increase of the young old (65+) caring for the oldest old (85+)
- Paid care workers often are young people with ethnic backgrounds; this sets up some cross-cultural issues
- The 85+ who are frail and aging in place need more family care; this need strains middle-aged baby boomer working women

- Taking care of parents and children places stress on women
- Senior women lead corporations to innovate in support of caregivers; although the number of programs stay small, they provide some models
- Church women exert leadership in supporting elders, particularly ethnic minorities

- Older new consumers will buy a lot of services, spawning some new local caregiving businesses; and they will be more independent of their families
- Techno-savvy older new consumers will build social networks independent of family; they will be supported in part by online communities

Older Workers

- Elders are increasingly able to work and want to work
- Retirement age moves to 70, because of better health and increased longevity
- Ethnic minorities face continued discrimination in the workplace
- Businesses slowly realize the value of older workers

- Few older women will stay in the work-force past 60 during the next decade; they are discriminated against in traditional workplaces and hit “glass ceilings”
- More senior corporate women in their 50s start up businesses so they can have flexible schedules
- Look for an increase in the numbers of women who leave the traditional work-force because of caregiving responsibilities
- California experiences fast growth in women-owned businesses; look for older women to participate

- Older new consumers will work part time in high-end jobs well into their 70s, and some will work into their early 80s
- As it becomes known that learning maintains mental acuity, look for educational institutions to cater to older new consumers
- Older new consumers will begin a strong fight against job discrimination in traditional workplaces

Regional Resource Maldistribution

- Communities with large aging populations will tax local governments, because services they need are not covered by federal entitlements
- Most California communities are not elder-friendly in terms of services and attitudes
- California divides into good and poor communities for aging
- There is a growing mismatch between where elders live and where community resources are

- Women politicians lead public-policy innovations
- Neighborhood networks form to organize services
- More women get into local politics to work on aging issues

- Older new consumers could become leaders in their local communities and begin to build California’s social capital
- Older new consumer communities will attract more resources; some communities become model aging communities

Low Savings and Inadequate Retirement Income

- More women in their 50s will have to give up full-time work to meet caregiving demands, thereby losing retirement and health benefits
- As elders age and deplete their assets, they become more dependent on family members

- Many older people will need to work because they need the income to support their longer lives
- One-third of California's baby boomers will have inadequate retirement income
- Look for more elders to start new careers

- Local governments in poorer counties will feel strained because low-income elders need more community services and have little income to pay for them; there are more needs and more mismatch at the community level
- Churches take on new roles and lead in organizing and providing services for low-income elders.
- There will be more old, ethnic ghetto neighborhoods, particularly in Southern California cities

Increasing Health Care Costs

- Middle-income and lower-income families dip into savings at midlife to pay for care of elders
- Baby boomers have to choose between paying for their children's education and their elderly parents' care

- New types of social organizations will be developed and supported by older volunteers to improve health care coordination
- New consumer direct services to help keep prices down
- There will be few cost incentives to integrate care

- Look for an increased demand for public services in low-income countries and cities
- Managed care will be consolidated in high-income, high-population areas
- Bartering in home services increases

New Information and Medical Technologies

- Look for an increase in devices designed to help women juggle care responsibilities
- New effective online communities become part of every caretaker's life
- The Internet makes it easier to manage the needs of aging parents from a distance

- Technologies support flexible work at home; the 60-to-65 group works longer in new innovative arrangements
- Look for a surge in elder-run Internet businesses
- New careers emerge in senior health care
- New technologies help the disabled stay in the workforce longer

- Elder-friendly communities are highly networked and wired—a big draw
- Communities tap into resources at a distance
- Look for more experiments in telehealth to offset maldistribution

Nine Critical Issues

THE SHIFTING LANDSCAPE OF GROWING OLDER IN CALIFORNIA

The larger forces affecting the elderly, which we identified in the previous chapter as “drivers,” are creating large-scale demographic changes in California’s aging population. Still, there are other immediate and ongoing critical issues within the field of aging that face elders, caregivers, service providers, and policymakers alike.

The effects of an aging population will be felt in virtually all aspects of California life. Creative and farsighted responses to these critical issues within the field of aging will do much to shape the aging agenda over the next few years.

The critical issues examined in this chapter include:

- The New Pioneers: 80-to-100-Year-Old Californians
- The Haves and the Have-Nots: Growing Polarization Among the Elderly
- California’s Ethnically Diverse Older Population: The Rich Legacy of Many Cultures
- The Growing Vulnerability of Older Women
- Elder Medical Care: Fragmentation of Financing, Programs, and Services
- The Housing Challenge: A Growing Need for Senior Housing and Community-Based Services
- The Caregivers’ Conundrum
- California’s Aging Workforce: Challenges and Opportunities
- California Community Readiness: Regional Maldistribution of Resources

“The challenge of global aging, like a massive iceberg, looms ahead in the future of the largest and most affluent economies of the world. Visible above the waterline are the unprecedented growth in the number of elderly and the unprecedented decline in the number of youth over the next several decades. Lurking beneath the waves, and not yet widely understood, are the wrenching economic and social costs that will accompany this demographic transformation ...”

—Opening in *Gray Dawn*, by Peter G. Peterson

THE NEW PIONEERS: 80-TO-100-YEAR-OLD CALIFORNIANS

The pioneer women and men who migrated to California's golden hills and valleys in the mid 1800s likely considered themselves elderly if they reached their 40s; such was life expectancy in those days. Even at the turn of the century, average life expectancy was only 47. Indeed, not until a couple of decades ago could most Californians even *imagine* that there was life beyond 65 or 70. Today, however, a growing number of Californians, especially women, are living well into their 80s and 90s, and some will live past 100. Today's 80-year-old Californians are truly new-style pioneers—only this time they

are blazing trails of new ways of living, embracing technological advances, picking up the new tools of the information age, and growing old amid comforts (and challenges) that most never imagined when they were young. These elderly never expected to live this long—or this well. People over 85 are the fastest-growing population group in America. Despite this fact, most people, whatever their age, still have the mind-set that 65 is old. Yet isn't it possible that 65 is now just the end of *middle age*, and that *old age* stretches to the century mark?

"It is estimated that in the forty-five hundred years from the Bronze Age to the year 1900, life expectancy increased twenty-seven years, and that in the short period from 1900 to 1990 it increased by at least that much. The changes have been so dramatic that it is currently estimated that of all the human beings who have ever lived to be sixty-five or older, half are currently alive."

—John Rowe and Robert Kahn, *Successful Aging*

OUTLOOK TO 2010

- Given increases in longevity and advances in medical technology, there will likely be more than 638,166 Californians over the age of 85 (a low forecast) in 2010. About 60% of women and 25% of men who reach 60 will live to be at least 85. This oldest-old group will be ethnically diverse and will predominantly be female.
- Real government expenditures will grow continuously because of this demographic pressure. The 85+ age group will consume a significant share of national and state health care resources. Benefits for this age group will remain guarded, while benefits will be chipped away for the young old, age 60 to 80, at least until the baby boomers reach 65 to 70.
- Availability of long-term care will be inadequate, and demand will rise. The quality of nursing homes will remain a problem, but there will be increasing quality of in-home support services and day health programs. Public policy will not keep pace, nor will California likely be ready for the rapid rise of the oldest old, people 85 and older, as the baby boomers reach 85. The public policy approach will remain incremental, piecemeal, and will focus on who pays.
- Four-generation families in California will increase although many extended families will not share households. By 2010, more Californians in general will have families that span several generations—a trend that will be driven by increased longevity.
- Most of the oldest old will lack health care insurance other than Medicare and Medicaid. As the shift from defined benefit to defined contribution becomes more prevalent, fewer employers will offer retirement health care benefits. Only people with the financial means will be able to buy supplemental health care insurance; many elders will be vulnerable to the high costs of health care.
- More 85+ Californians will enjoy better health and higher quality of life. Today's 65- and 70-year-olds are adjusting to a longer life span. They will be early adopters of successful aging practices, and disability will begin to drop and continue a downward trend well beyond 2010.

Who Will Be the Oldest Old?

Not everybody will live to be 85+ in California, of course. Both gender and ethnicity account for differences in life expectancy (see Table 3-1 and Table 3-2).

- *Women.* The number of women in the oldest-old population in California will increase by 65% between 1990 and 2000, and women will account for 68% of that group. This trend will continue well into the 21st century; by 2010, the number of women among the oldest old will increase by an additional 77%.
- *Non-Hispanic Whites.* Growth of the oldest old will be dominated by non-Hispanic white Californians for the next several decades. Both Latinos and Asians will add to the numbers of people over 85 during the

next 40 years, but whites will remain the largest group.

- *Single Centenarians.* There will be more 100+ Californians (the state had some 10,000 in 1998 alone). Most of these will be single non-Hispanic white women who are widows.
- *Southern California City Dwellers.* Most of the oldest old will live in the cities of the Southland. Los Angeles will have the most elderly in terms of overall numbers, as well as for each ethnic group.
- *Some 50% Healthy, 50% Sick.* Half of the 85+ population will be healthy and live independently. Their health status and living conditions will be linked to income, education, and use of information technology.

A Portrait of California's Oldest Old

In California, the number of oldest old will increase from 449,000 in 2000 to over 1 million by 2030, when the eldest baby boomer turns 85, and will grow even more steeply thereafter. More than 70% of people in America today live to 65. Life expectancy for people reaching 65 today is 83 years. This is a full five years longer than in 1900 (see Figure 3-1).

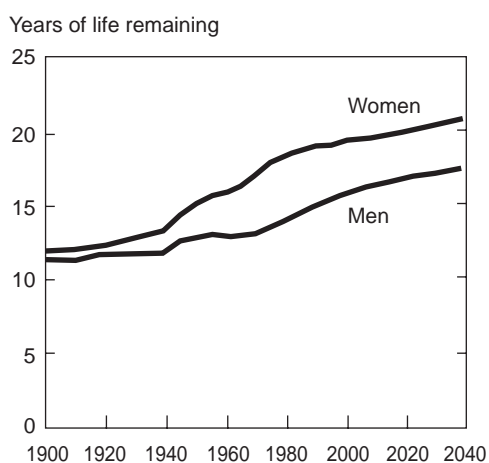
In the first half of this century, gains in life expectancy came from lower mortality rates in childhood, better treatment of young adults with infectious disease, and better prenatal care. Since then, additional gains have come from declining death rates for middle-aged and older people. Many 90-year-old Californians can expect to be quite healthy and to live independently, particularly if neighborhoods and communities learn how to make the environment "aging-friendly."

Table 3-1
Average Life Expectancy at Birth Varies in California (Years)

White Females	79.5
Asian/Other Females	75.5
African-American Females	73.7
White Males	73.1
Asian/Other Males	67.3
African-American Males	64.6

Source: State of California, Office of Statewide Health Planning and Development, *California Health Care Fact Book*, 1999.

Figure 3-1
Life Expectancy at Age 65 Has Increased Throughout the 20th Century, United States



Source: Economic Report of the President, February 1999.

Table 3-2
California's 85+ Population Is Diverse
(Number and percent of people 85+, by ethnicity)

	1990	%	2000	%	2010	%	2020	%	2030	%	2040	%
Total	293,383	100	449,762	100	638,166	100	727,737	100	1,032,655	100	1,745,939	100
Whites	243,915	83	337,128	75	448,133	70	459,464	63	606,774	59	927,025	53
Latinos	24,818	8	56,213	12	90,246	14	129,222	18	209,272	20	418,002	24
Asians/ Pacific Islanders	11,660	4	35,807	8	70,507	11	100,220	14	164,457	16	315,090	18
African Americans	12,143	4	18,268	4	25,424	4	32,953	5	42,432	4	70,757	4
Native Americans	847	0	2,346	1	3,856	1	5,878	1	9,720	1	15,065	1

Source: State of California, Department of Finance.

Toward Successful Aging: More Health, Less Disability

As Californians age, chronic conditions will increase but will not necessarily be accompanied by increased disability. The elderly are tending to be less chronically disabled, and some experts even hypothesize that death rates will taper off as life expectancy increases and new therapies (better pharmaceuticals, less-invasive surgeries) and improved lifestyles postpone disability.

More and more independent studies (including those conducted by Duke University and The National Institute on Health) have found a steady, year-to-year decline in the number of 65+ Americans who are physically limited and unable to take care of themselves. One study showed that chronic disability among the elderly decreased by 15% over a period of 15 years (see Figure 3–2). Another showed that the prevalence of chronic disability declined from 24.9% to 21.3%. Together, these studies show a decline in chronic disability among the elderly. Indeed, the elderly account for less than one-third of people with chronic diseases causing limitations or disability (see Figure 3–3), and new studies find that older Americans are growing progressively healthier.

Despite these heartening trends, Californians need to lead the way in pioneering a new concept of aging and move away from the medicalization of aging. According to Rowe and Kahn, in *Successful Aging*, successful aging has three components:

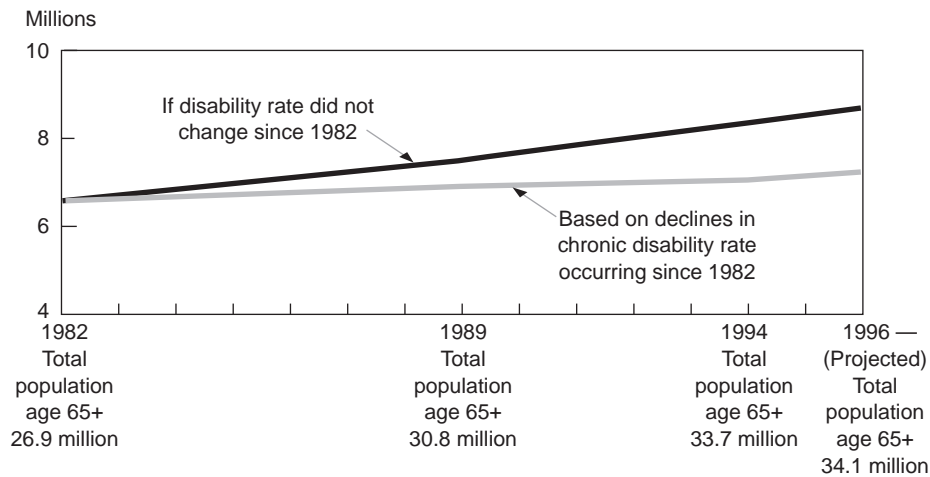
- Low risk of disease and disease-related disability
- High mental and physical functioning
- Active engagement with life

Although all three components are important, a major increase in the quality of life for the oldest old can be attributed squarely to the third factor: active engagement with life. Many elderly feel lonely and isolated, even if they are members of caring families, for few families are adept at integrating the elderly into daily family life. Social connectedness is a powerful predictor of good health and can delay or prevent disability, especially among the very old.

“If I’d known I would live this long I would have taken better care of myself.”

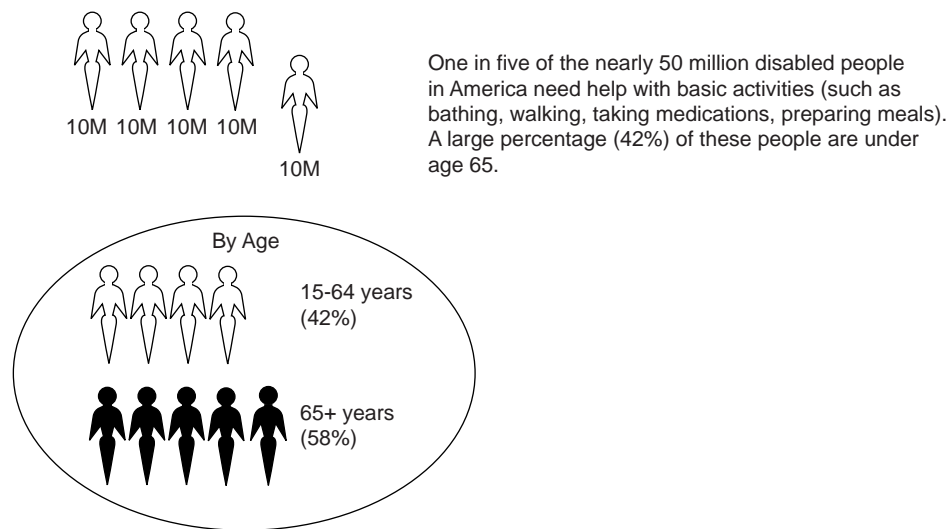
—Jazz musician Eubie Blake, at age 97

Figure 3-2
Chronic Disability Is Declining



Source: Manton, K.G., L. Corder, and E. Stallard. "Chronic Disability Trends in Elderly United States Populations: 1992-1994." *Proceedings of the National Academy of Sciences of the United States* (1997) 94:2593-2598.

Figure 3-3
One in Five Disabled People Needs Help with Basic Daily Activities, and a Large Proportion Are Under 65



Source: Robert Wood Johnson Foundation, *Chronic Care in America: A 21st Century Challenge*, August 1996.

Dispelling the Myths

Although older Californians are living longer, healthier, and happier lives, attitudes and values about aging remain stuck in the past, reflecting old ideas formed before modern advances in science and medicine. Social attitudes still associate advanced age with dependency, higher prevalence of disease and illness, declining mental capacity, and general withdrawal from community life

and activity, although the lives of many older Californians belie this profile.

As life expectancy increases, many older Californians will spend 35 years or more in retirement, with better health and greater activity than those of previous generations. Dispelling the myths of aging will help the oldest old age successfully (see Table 3–3).

“Pumping iron—You probably think of weight lifting or other strength training as a young person’s sport. But that’s a stereotype we must erase because with training it can make a tremendous difference in older people’s strength and overall ability to function. Strength or ‘resistance’ training increases the size and strength of muscles without improving endurance. Even the ‘oldest old’ respond well to resistance training. Their muscles grow in size and strength much as younger people’s do.”

—John Rowe and Robert Kahn, *Successful Aging*

Table 3–3
Myths, Perceptions, and Truths About Growing Older

Myth/Perception	Truth
<p>Illness “Most elders are sick or disabled.”</p>	<p>The majority of older people are healthy enough to engage in normal activities. Only a small proportion are institutionalized, and more than 82% report having no limitations in their activities of daily living. Only 5% of the nation’s elderly are in nursing homes at any one time.</p>
<p>Chronic conditions “A majority of persons with chronic conditions are 65 and older.”</p>	<p>The elderly represent less than one-third of those who have chronic conditions causing limitations and disabilities.</p>
<p>Mental decline “Mental abilities begin to decline from middle age onward, especially abilities to learn and remember, and cognitive impairment is an inevitable part of the aging process.”</p>	<p>Most older people retain their normal mental abilities, including the ability to learn and remember. Differences between the young and old can be explained by variables other than age, such as illness, motivation, learning styles, and level of education.</p>
<p>Uselessness “The majority of old people are disabled by a physical or mental illness and unable to work. Those who do are unproductive.”</p>	<p>Older people are living longer and healthier lives, and they frequently work long into “retirement age.”</p>
<p>Work “Older workers are unproductive and will not play a role in the changing and evolving landscape of work.”</p>	<p>More older people are interested in second and third careers. Many more retired people are returning to work, some out of necessity and others out of interest. An aging workforce will compel companies to rethink their organizational structures, to tap into the knowledge of their older workers.</p>
<p>Political power “The elderly are a potent, self-interested political force.”</p>	<p>The elderly constitute a large portion of participating voters and do exert some influence; however, elders do not vote as a bloc, and thus have significantly less political power than presumed. Furthermore, few legislators are currently championing the issues of the elderly, and most believe aging issues do not require formal interventions.</p>

Source: IFTF; School of Social Welfare, University of California at Berkeley, 1994; Robert Wood Johnson Foundation, *Chronic Care in America: A 21st Century Challenge*, August 1996.

2

**THE HAVES AND THE HAVE-NOTS:
GROWING POLARIZATION AMONG THE ELDERLY**

The number of older Californians is growing at both ends of the income scale, creating two profoundly different groups: people with annual incomes over \$50,000 and people with incomes below \$15,000, with a diverse middle class in between. Older Californians in higher income brackets predominantly are white, a trend that will accelerate as white wealthy baby boomers age. Those with incomes under \$15,000 are, for the most part, the minority elderly—a trend that also will accelerate as “boomers of color” age. The elderly at the middle-income level are more evenly distributed along ethnic lines, although

middle-income minorities tend to have fewer assets and are more likely to slide into poverty than their white counterparts, and to do so more quickly. Richer and poorer older populations are invisible to each other, because they live in different neighborhoods and ethnic communities. The gap between older people from different cultural backgrounds is a significant and a pressing issue. These societal and income gaps are particularly prevalent in Southern California, especially in Los Angeles and San Diego, where many different elder subpopulations live close together.

“The overall economic picture of the elderly in the United States has improved significantly since 1970, when 25% of people over 65 were below the poverty level. By 1995 that percentage had dropped to 10.5%. However, the improving economic situation primarily applies to those who are married and white or male, single, and white.”

—ITF

OUTLOOK TO 2010

- A small but growing number of Californians, especially those over 75, will slide into poverty as life expectancy outstrips savings and retirement plans. This vulnerable group will be, for the most part, older single women.
- Income disparity throughout society is expected to intensify between 2000 and 2010, including more poverty among the elders. The first wave of baby boomers will retire in 2010, and some will experience increased poverty rates, from 9% to 14%. Single older Latinos are most at risk.
- There is a persistent underclass among baby boomers whose education and work histories will not provide them with adequate retirement income or much Social Security.
- A broad spectrum of older Californians who have not saved adequately for retirement will find themselves at high risk of sliding into poverty, particularly if they are long-lived. Poorer elderly will depend on Social Security and public welfare programs for income. The uncertain future of these entitlements is a concern for those elderly in the low-income tiers, who depend on these sources instead of pensions and savings.
- Income gaps among racial groups will increase among elders. California's elderly are becoming increasingly polarized as "haves" and "have-nots." The wealthy include mostly white and Asian groups, which are characterized by power and influence. On the other end of the spectrum are a lower-income group of Latinos and African Americans, which is slipping further and further into poverty and is disproportionately female.
- Many older women with adequate income at the beginning of their older years will slide into poverty. As women become widowed and are longer-lived, their incomes could dwindle to half their former amount. Outliving income will be common among older women and will have consequences for health care and long-term care services.
- Affluent older Californians will become a large niche market early in the 21st century. Their growing service needs will significantly impact the economies of the areas where they live.

The Haves: Health, Wealth, and Political and Market Clout

The booming California economy has created a relatively wealthy middle class led by the well-educated baby boomers and supported by the technology industry. Older consumers control most of the wealth and disposable income in the Golden State, and their consumption patterns will increasingly play a major economic role.

**Health-Conscious Elders—
A Link to Successful Aging**

Income and health go together. Older, well-educated Californians live healthier lives than their poorer, less-educated peers, and they are becoming highly health conscious as consumers. They have a growing awareness that they will live longer and better if they adopt healthful practices. This understanding will create a vast market of new products, from pharmaceuticals, indoor exercise equipment, and memory-enhancing drugs to special foods, speech recognition technology, and elder-friendly household devices.

A Wealthy Subpopulation

White older Californians account for the majority of high-income households among the elderly. Some 85% of all high-income households are white, although only 16% of all white households age 65 and older have incomes above \$50,000. In addition, about 20% of Asian and Pacific Islander elderly have high incomes (see Table 3–4).

Political Clout Is Growing

Although the older white population tends to vote consistently, the elderly as a group lack sufficient political clout to force more attention to their needs, beyond saving Medicare and Social Security. When the baby boomers reach 65, that will change. These aggressive, better-organized, and highly informed elderly will push for policies that support their needs—and will possess the financial clout to back up their demands. These elderly also will have the potential to help support their less-fortunate peers, but only if they take the opportunity to learn about their lives and needs, from which they are far removed. For example, will financially well-off and educated elderly white women take up the cause of poorer elderly women of color? Finding a way to define and address the issues of elderly women across income and racial/ethnic lines will be a challenge.

The business community's great awakening to the expanding desires of well-heeled older consumers is gradually changing the face of the economy.

Ford, the car manufacturer, is already developing the "gray-mobile" for the older person who may not suffer from serious disease but is prone to minor ailments such as stiff necks and poor eyesight.

Table 3–4
California’s Elder Households, by Income and Key Characteristics

Income Level	Key Characteristics	Specific Issues and Needs
High Income		
<p>\$50,000 and above</p> <ul style="list-style-type: none"> • 16% of all 65+ households • 85% of all high-income households are white; 20% of Asian and Pacific Islander 65+ households are high-income 	<p>Pensions, savings, and other accumulated wealth are main sources of income.</p> <p>Medicare plus supplementary insurance. Some households with long-term care insurance.</p> <p>Large proportions are new consumers—educated, with discretionary income, and use online services.</p> <p>Maintain preretirement economic status and quality of life.</p>	<p>Maintain independence.</p> <p>Seek continuing education opportunities.</p> <p>Own home or live in retirement and assisted-living settings.</p> <p>Leisure activities, volunteer opportunities, and community involvement.</p> <p>Actively involved in health and treatment decisions. Consumer of health information for self-care.</p>
Middle Income		
<p>\$15,000 to \$49,999</p> <ul style="list-style-type: none"> • 47% of all 65+ households • 83% of middle-income households in California are white 	<p>Rely on diverse sources of income—Social Security and subsidized programs help maintain preretirement lifestyle.</p> <p>Strong sense of entitlement.</p> <p>Medicare health coverage with some private insurance. Largely enrolled in managed care.</p> <p>Smaller proportion of information and technology-savvy consumers.</p>	<p>Open to managed care. Fear spending down for Medi-Cal long-term care coverage.</p> <p>Own home and rely on in-home support services.</p> <p>Seek postretirement part-time employment for supplementary income.</p>
Low Income		
<p>\$14,999 and below</p> <ul style="list-style-type: none"> • 37% of all 65+ households • Large proportion of minority low-income households • 55% of African-American 65+ households are low-income; 47% of Latino 65+ households are low-income 	<p>Social Security is major source of income, supplemented by other means-tested welfare programs such as SSI, food stamps, HUD, etc. Adult children are also source of supplementary income.</p> <p>Medicare and Medi-Cal health coverage. Access mostly community safety-net services. Not enrolled in managed care—mainstream health care.</p> <p>Traditional consumers. Not online.</p> <p>Disproportionately minorities and single older women.</p>	<p>Higher rates of chronic disability.</p> <p>Need language, cultural, and gender-appropriate services.</p> <p>Some own homes. Large demand for low-income housing exceeds supply. Rely on community-based services.</p> <p>Fixed income. Spend high proportion of income on out-of-pocket health care costs, particularly for drugs.</p> <p>Need new financial products to support management of income, including more innovation in reverse mortgages.</p>

Source: IFTF

**The Have-Nots: Income Gaps Remain
Linked to Race and Gender**

California's older population includes a widerange of people age 65 to 100+, who are characterized by extreme diversity in income, health status, race and ethnicity, functional limitations, living situations, geographic settings, and other factors. Significant differences in income persist (see Table 3–5), and the relative wealth of the baby boom generation masks the existence of an emerging underclass of elderly Californians.

Income differences also persist for subgroups defined by age, sex, race, ethnicity, marital status, living arrangements, educational attainment, former occupational status, and work history. In 2010, over 12% of the nation's older population will be poor or near poor. Minority populations will have higher levels of poverty than whites and thus have less access to adequate health care, housing, and other basic needs.

Gaps Among California's Older Population

Living Below Poverty

- 33.8% of older African Americans versus 10.1% of older white Americans

Living Below Poverty

- 22.5% of older Hispanics versus 10.1% of older non-Hispanic white Americans

Social Security Payments

- \$538 monthly for women versus \$858 for men

Private Pension Payments

- \$328 annually for women versus \$622 for men

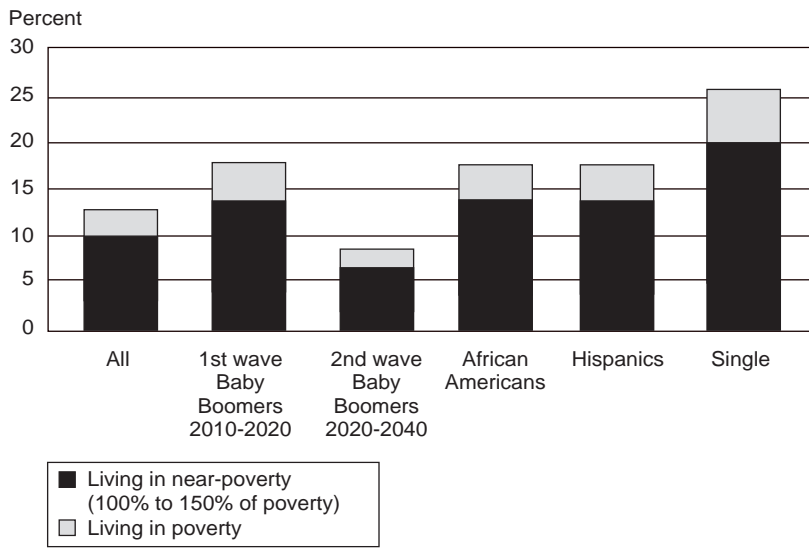
Source: IFTF; U.S. Census Bureau.

*Table 3–5
Income Gaps Among the Elderly*

<i>California Households 65+ Older</i>	<i>Low Income \$14,999 and Below</i>	<i>Middle Income \$15,000 to \$49,999</i>	<i>High Income \$50,000 and Above</i>
Percent	37	47	16
White	35	48	17
African-American	55	37	8
Native American	51	42	7
Asian/Pacific Islander	38	42	20
Other	49	42	9
Hispanic/Latino	47	43	11

Source: IFTF; U.S. Census Bureau.

*Figure 3–4
Rates of Poverty or Near-Poverty in 2010, United States*



Source: Lewin-VHI Prism Simulations

Increasing Vulnerability: Elders Are at Risk of Sliding Into Poverty

In 1998, fewer than 8% of older Californians lived in poverty; however, many more are at risk of sliding into that condition (the 1996 poverty threshold was \$7,525 for one person age 65 or older). In the mid 1990s, there were almost 1 million “vulnerable” elderly in California, defined as those with incomes below 200% of poverty. Today, approximately 29% of the people at risk are age 65 and older. People who are not covered by Medi-Cal (the state’s health care insurance for the “poorest poor”)—usually retired workers without private health care insurance benefits from their jobs—are extremely vulnerable to becoming poor, because of rising health care costs and unexpected out-of-pocket expenses. Many of these retirees worked productively at jobs that did not provide retirement health insurance or adequate pension funds. These vulnerable elders represent a varied group, diverse in age, race or ethnicity, and gender (see Figure 3–4).

Retirement Funds Are Spread Too Thin

Poorer subpopulations enter retirement with low incomes and few assets, based on low lifetime earnings and a lack of savings, which are generally caused by other factors, such as low educational attainment, a lack of marketable skills, and labor-market discrimination. Minorities also experience higher unemployment rates and long periods outside the labor market (highest among women) that further reduce the potential for accumulating retirement income.

But it is not only the poorer subpopulations that are at risk. There has been a trend to retire earlier, before 60 rather than at 65, during the past few decades. Californians who will retire during the next ten years do not plan on increased longevity, and many will be left with only Social Security benefits as they approach their mid 70s.

Out-of-Pocket Health Care Costs Are Rising

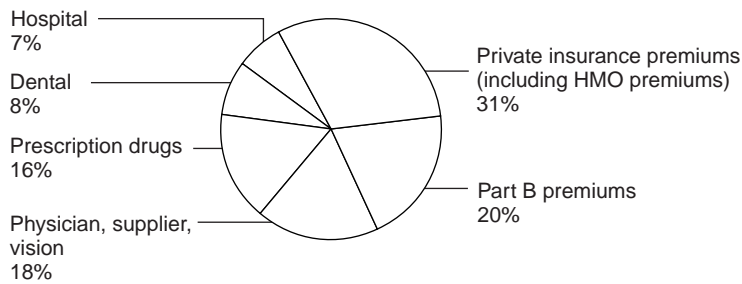
Health care expenses paid for out of pocket place stress on vulnerable elders, putting them at greater risk of poverty and often forcing them to choose between going on welfare or forgoing health care altogether. Single women, who are often widows and minorities, are at greatest risk. They tend to have lower incomes and fewer opportunities to purchase private health care insurance. The elderly living below the poverty level paid 34% of income for out-of-pocket health care in 1994, while those with incomes between 100% and 200% of the poverty level paid 26% (see Figures 3–5 and 3–6).

Vulnerable Elderly Are at Risk

Overall statistics tend to mask differences among subgroups of elders. Here are some of the most vulnerable groups:

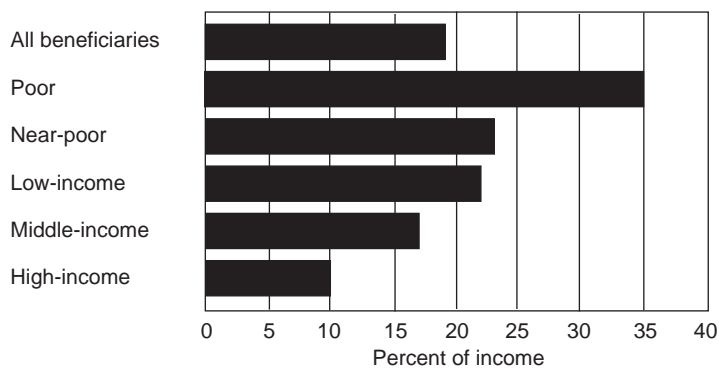
- Single Latinos
- Older African-American women—50% live alone in poverty.
- Middle-income elderly with chronic diseases but without pharmacy benefits
- Retired middle-income workers lacking pension health benefits
- Widows who lost health or retirement benefits when their husbands died

Figure 3–5
Average Out-of-Pocket Health Spending for Medicare Beneficiaries, by Expense Category, United States, 1997



Source: Medicare Benefits Simulation Model

Figure 3–6
The Poor and Near-Poor Spend More of Their Income on Out-of-Pocket Health Costs (Average out-of-pocket health costs for Medicare beneficiaries, United States)



Income status definitions:
 poor = below poverty; near-poor = 100% to 125% of poverty; low-income = 126% to 200% of poverty; middle-income = over 201% to 400% of poverty; high-income = over 400% of poverty

Source: Medicare Benefits Simulation Model; AARP and Lewin

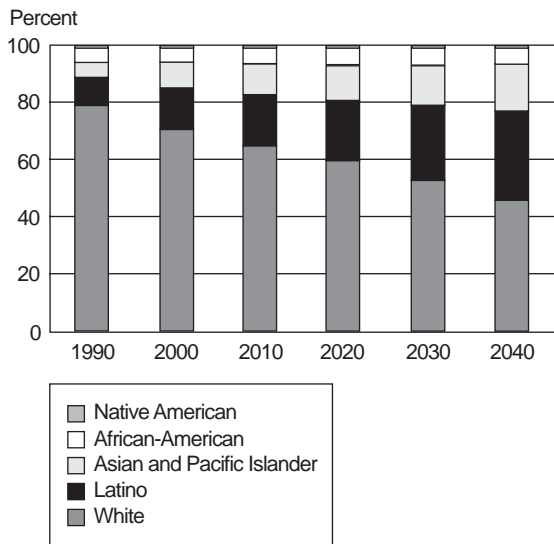
3

**CALIFORNIA'S ETHNICALLY DIVERSE OLDER POPULATION:
THE RICH LEGACY OF MANY CULTURES**

Demographic change in California is creating an increasingly multicultural and multilingual population, yet lack of information about ethnic diversity and its implications for elder care has stymied the growth of effective programs and policies. Existing data have their limitations; averages mask the diversity in the 65+ population in California. Minority elders in the state are typically identified as African American, Latino, Native American, and Asian/Pacific Islander (see Figure 3–7). Yet diverse heterogeneous populations exist within each of these seemingly monolithic ethnic groups. For example, “Hispanic” or “Latino” includes Puerto Ricans, Cubans, Mexicans, and Central Americans of any race.

Likewise, subgroups of African Americans, or any other race, can be differentiated by economic, education, geographic, and lifestyle characteristics. For instance, Asian-American elders represent tremendous ethnic and economic diversity. Asian Americans include U.S. citizens, naturalized citizens, and legal immigrants of Chinese, Japanese, Filipino, Korean, Southeast Asian, and East Asian Indian descent. Economically, Asian-American elders differ along many dimensions as well. For example, poverty rates for Japanese, Filipino, and East Asian Indians are among the lowest in the country, yet they are among the highest for more recent immigrant or war-refugee groups such as Laotian, Hmong, Cambodian, and Vietnamese elders. Within any racial group there are differences in individual status regarding health, income, education, and generation. This is important because their cultural attitudes toward aging are different. Given the current health care delivery system, built on assumptions about aging based on a white population, many barriers to access exist for these ethnic groups.

*Figure 3–7
California's Older Population Is Growing More Diverse*



Source: IFTF; State of California, Department of Finance.

OUTLOOK TO 2010

- Knowledge about ethnic elders will remain sparse. The lack of data and research will create a gap in our knowledge about minority elders in California and their needs. Few programs and services exist now that specifically focus on the needs of older ethnic groups. It is unlikely that more programs will be created that will best serve the state's minority elders over the next ten years.
- Although poverty rates for older Californians have fallen, rates for most ethnic elders, particularly Latinos and African Americans, will increase. They will remain the second most vulnerable older group after single women.
- Cultural and language barriers to health, social services, and long-term care will prevent many ethnic elders in California from accessing the care they need, which in turn will increase their health risks. Barriers to care will impact these elders' ability to manage their own chronic illnesses and overall health.
- Although the ethnic elderly will account for 35% of the 65+ population in 2010, much-needed policy and service programs will remain sparse.
- Asian elders will be the fastest-growing group of older Californians until 2010, when the Latino elderly growth rates will surpass both Asian and white elderly growth rates in the next decade; Latinos will remain the state's fastest-growing race/ethnic subgroup for all ages during the next several decades.
- Aging immigrants without sources of retirement income and health insurance will increase in number. This subpopulation is primarily made up of Asians who followed their children to California in the 1960s and 1970s. They suffer much social isolation because family life in California is very different than they expected. With devolution of health and social services continuing unabated, aging immigrants left without a family safety net will be at risk for poverty and poor health.
- Caregivers for many minority elders will come under pressure as more of California's ethnically diverse women enter the labor force. Traditionally, these women were expected to care for the aging members of their families. However, many young and middle-aged working women, particularly Latinos and Asians, will find they are unable to care for their parents or their children as they once did. As a result, minority elders and their caregivers will find few support choices, as culturally and linguistically relevant programs will be scarce.

Minority Elders Remain Invisible Despite Their Growing Numbers

Even though California is known for its enormous ethnic diversity, it is almost impossible to obtain research and analysis beyond statewide demographic numbers on the aging population. Research and data on minority elderly are rarely collected, synthesized, or analyzed, although this information would be enormously helpful in identifying the needs and well-being of the state's aging ethnic population. What we do know is they will grow to become 35% of elders over the next decade.

The Oldest Old Will Grow Slowly

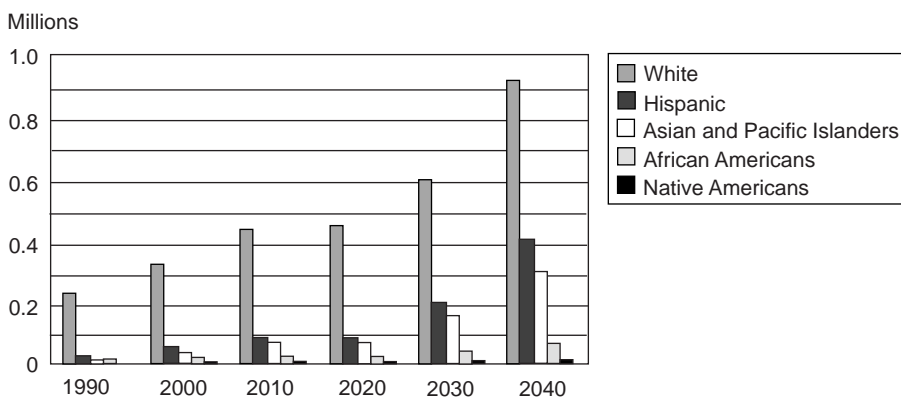
California is growing older with its immigrant and ethnically diverse populations. For a few more decades they will be relatively small in number compared with whites (see Figure 3–8). Due to the history of immigra-

tion in California, this group will be uniquely different from age cohorts that follow. They have experienced many problems associated with immigrant status and have weathered a great deal of racism and institutional prejudice. To a large extent, they have been ignored by everyone but their families and social networks. They also experience a generation gap within their families, especially with their grandchildren, who may speak different languages and have different beliefs and expectations of family obligations.

California Elders Are Divided by Race and Income

Despite substantially falling poverty rates among California's older citizens as a whole in the past 20 years, poverty remains high for most ethnic groups, ranging from two to four

Figure 3–8
Elderly Ethnic 85+ in California Are Growing



Source: IFTF; Demographic Research Unit, State of California, Department of Finance.

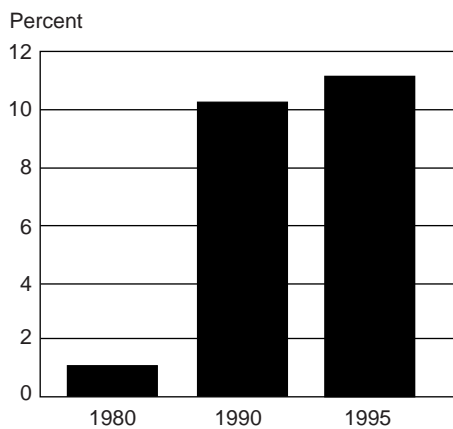
times that of whites. The higher poverty rates for minorities result from a combination of factors over the course of their lives: inadequate education, discrimination in hiring and rates of pay, work in low-wage jobs, high unemployment, and intermittent employment, among other factors. Most of the impoverished ethnic elders worked at jobs that did not offer pensions or health benefits. Some are legal or illegal immigrants with little security of income and access to the formal health system; therefore, they have limited resources during retirement.

**Aging Californians Are Divided
by Many Languages**

California's ethnic diversity can be heard in the languages spoken by its 34 million residents; increasingly, large numbers of citi-

zens are primary speakers of Spanish, Mandarin, Tagalog, or other languages besides English (see Figure 3-9). Already, large counties such as Los Angeles County and the City and County of San Francisco are challenged to provide health and social services in more than 100 different languages. Many of today's and tomorrow's ethnic elders do not speak English well, which will be a significant barrier to accessing services. Future studies examining elders' needs, behavior in seeking health care, and social and cultural roles in families and communities will greatly aid the development of appropriate policies and programs.

*Figure 3-9
Californians Who Speak a Language Other Than English at Home
(Percent of California households)*



Source: IFTF; U.S. Department of Commerce; U.S. Census Bureau; and Field Research, *California State Library Survey*, 1995.

**Diversity in Aging:
What Does It Mean?**

As we look beyond the millennium, we should ask ourselves, “What does ethnic diversity in aging mean? Should we care?” When we examine the growth rates of California’s minority elderly over the next several decades, the importance of improving our understanding comes into focus (see Table 3–6).

Traditionally, two perspectives on ethnic diversity in aging have dominated. The first holds that minority elderly are at a double disadvantage in American society, particularly with regard to economic status and health, due to their minority status and their place in an ageist society. Although this perspective provides some insight into the experience of minority elderly, it is far too limited. A second, sometimes competing, perspective holds that differences in status between minority and white populations are reduced over the course of a lifetime as both groups experience similar problems and so-

cial barriers in old age. Again, this perspective is far too simplistic and ignores the effects and experience of cultural factors. In California, where the high rate of immigration and ethnic diversification of the population have stretched the comforts of society and have gone farther than anywhere else in America, perspectives need to evolve. The use of a white European-American standard model from which other populations deviate is now rejected and simply not useful. California needs to adapt a perspective on diversity in aging that moves beyond this simplistic model. When we look at issues of diversity in aging, we’ll need to distinguish between that which is generic and common to all older persons irrespective of race, language, and ethnicity on the one hand, and those particular factors that necessitate culturally and linguistically specific responses to each on the other hand.

*Table 3–6
Growing Diversity Among Older Californians
(Average annual growth rate)*

	1990–2010	2010–2030	2030–2050
All 65 and older	1.9	3.4	2.7
Whites	0.9	2.4	2.0
Latinos	4.7	5.5	6.4
Asians	5.3	4.5	4.2
African Americans	2.1	3.6	3.8
Native Americans	5.1	3.7	2.1

Source: IFTF; State of California, Department of Finance.

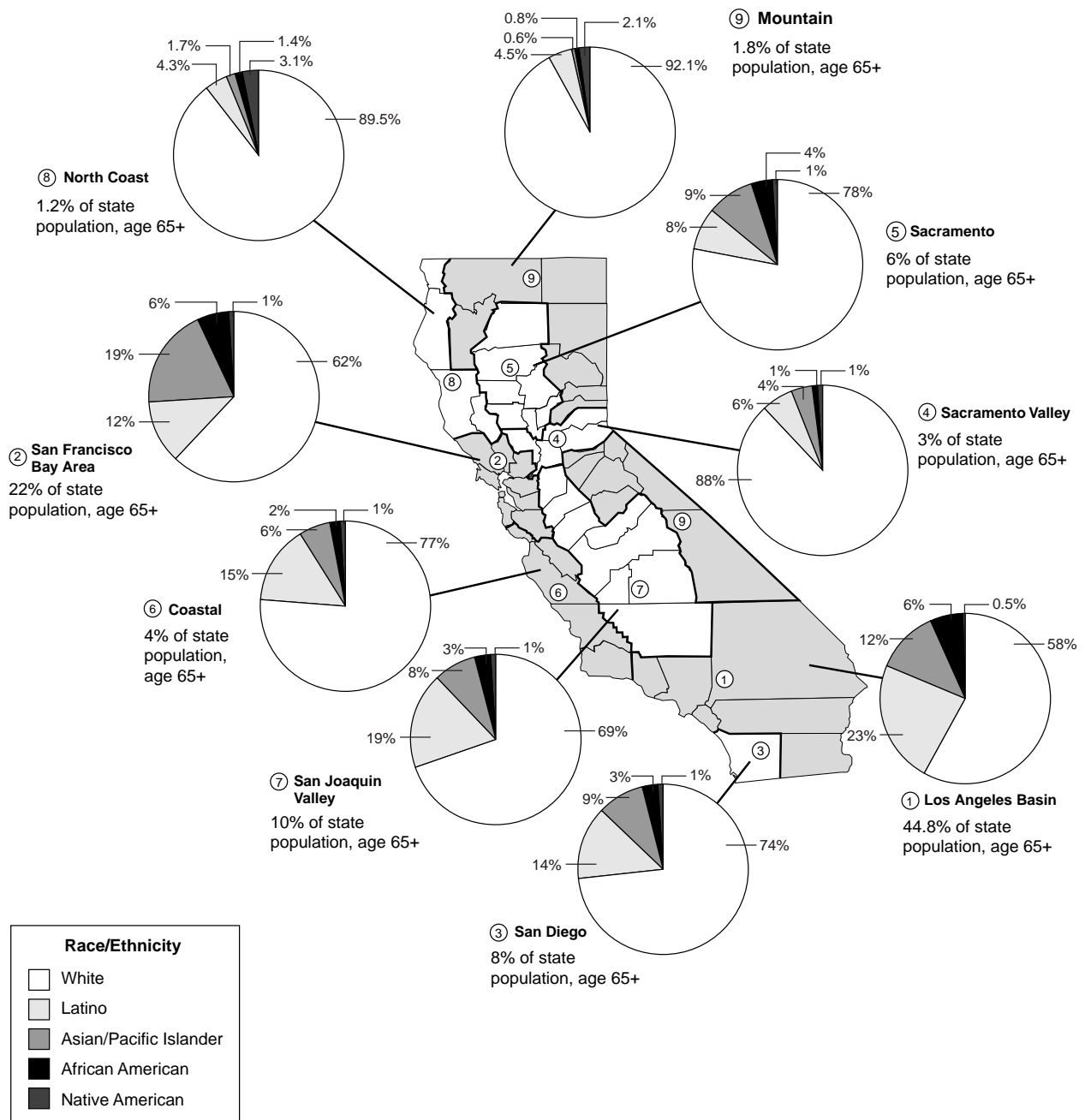
**THE VARIED PROFILE OF
ETHNIC AGING BELIEFS AND PRACTICES**

- Much variation within groups in language, cultural beliefs, social class, and religion.
- Many different levels of acculturation and assimilation.
- Different immigration patterns and time periods.
- Different experiences of racism and prejudice.
- Tend not to use formal long-term care or nursing home services, more care and support within family or close friends, strong cultural barriers to nonfamily care.
- Tend to live in nuclear family until death of spouse. Most ethnic elders are dispersed throughout multicultural neighborhoods and are not clustered by race.
- Different views and expectations of aging.
- Tend to experience and die from same diseases as whites, although incidence of disease may be different.
- Poverty masked by living with families.

**A WINDOW ON
CALIFORNIA'S ETHNIC ELDERLS**

This map (see Figure 3–10) and the following snapshots of California's ethnic elders provide a very brief and simple look at this population. The diversity of this growing population is so enormous and the data and information about them so sparse that it is virtually impossible to provide a good descriptive analysis and a meaningful forecast of their future in the Golden State beyond demographic growth.

Figure 3–10
California's Ethnically Diverse Elders Live in Many Places



Source: IFTF; State of California, Department of Finance.

LATINOS

Immigration and Migration. Because California belonged to Mexico, Latinos' historical and cultural roots are deep. Mexicans are the largest group of immigrants and were long the largest group of agricultural migrants in California. They have been known for their continuous legal and illegal flow of people for decades. They have very different histories and cultures from other Latino groups that immigrated to California from Central America, Guatemala, El Salvador, Honduras, and Nicaragua. Mexican immigrants tend to be young, and they come to find work, to settle down, and to begin a new life. This pattern will continue into the foreseeable future.

Aging and Health Beliefs. Latinos view aging pragmatically as simply the last stage of life. Belief in folk medicine and practitioners such as *curanderos* and *yerbistas* varies widely and diminishes in importance in successive generations within families, but it continues to be strong within the flow of new immigrants. The cultural themes of *personalismo* (personal not impersonal social interactions) and *espiritismo* (good and evil spirits) are more important.

Population Growth and Regional Distribution. The Latino elderly population will grow at an average annual rate of 4.7% between 1990 and 2010. This growth will increase to 5.5% between 2010 and 2030 (see

Figure 3–11). In 2010, 60% of California's Latino elderly will live in the Los Angeles Basin and 35% will live in the San Francisco Bay Area.

Education. Elderly Latinos are the most educationally deprived of all elderly groups. The proportion of Latino elderly with no formal schooling is eight times higher than for white elderly. For Latino elders born in the United States, inadequate education can be attributed to the segregation practices common during this cohort's youth.

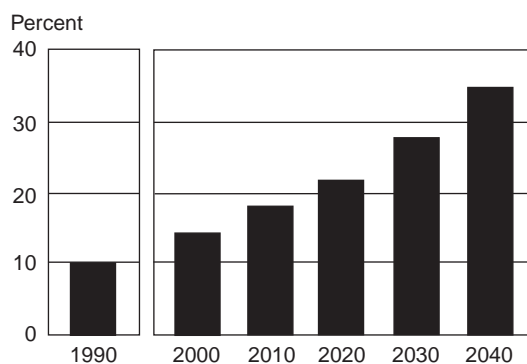
Poverty and Income. Although there is a growing Latino middle class in California, most older Latinos will be near-poor or poor. Histories of high levels of unemployment and low-wage jobs make poverty common among elderly Latinos. Frequent and extended periods of unemployment mean immediate financial hardship, but they also can disqualify a worker from receiving pension benefits due to vesting problems (to be fully insured by Social Security, workers must be in jobs covered by Social Security for at least ten years). Many Latino elderly worked as agricultural laborers or domestic workers, in temporary and part-time jobs, most of which were not covered by Social Security. Social Security computes incomeless years into an average yearly income, so that scattered periods of unemployment cause a significant reduction in monthly benefits.

Health Care Information Sources. Latino elderly consider physicians, friends, and family members the most credible sources of health information. The most effective venues for delivering health messages to large audiences are Spanish-language radio and television stations, churches, and social clubs.

Social Networks and Family Support. Latino families have strong bonds, with patterns of frequent interaction that are ex-

tremely important to their members. There is a deep sense of family obligation that often supersedes the needs or desires of individual family members. Traditionally, the elderly, who are held in high esteem, expect their families to assist them in their later years and also to treat them with respect. However, nuclear families are common and single older women will live with their families. Latino elders seldom are placed in nursing homes or long-term care.

Figure 3-11
Latinos 65+ in California



Source: IFTF; State of California, Department of Finance, Projected Total Population of California Counties

ASIAN AMERICANS AND PACIFIC ISLANDERS

Unfortunately, most statistics about the 100 or so different cultural groups from Asia and the Pacific Islands have been lumped together. Profiling them on a statewide basis or even a county or city basis is very difficult. They are a heterogeneous group. Each ethnic group has separate languages, cultures, and social structures, varied immigration histories, acculturation levels, language abilities, cohort experiences, and a broad range of socioeconomic status. Since 1990, the Philippines, mainland China, Korea, and Vietnam have accounted for the most documented elderly immigrants. These elderly constitute the largest group of foreign-born elders, in contrast to the Latinos, because of their recent immigration. About 50% of Asian/Pacific Islander elders live in California and another 20% live in Hawaii.

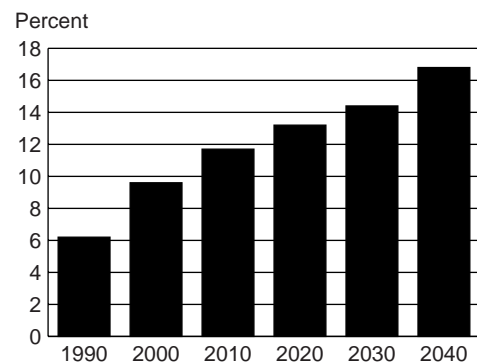
Population Growth and Regional Distribution. The Asian-American elderly population will grow at an average annual rate of 5.3% between 1990 and 2010. This growth will increase to 4.5% between 2010 and 2030 (see Figure 3-12). In 2010, 46% of California's Asian-American elderly will live in the Los Angeles Basin and 35% will live in the San Francisco Bay Area. Asian elders constitute the largest group of elders who followed their children to California since 1965. This group is now aging in place primarily in the Los Angeles Basin and San Francisco Bay Area.

Education. Asians have a bipolar distribution of their levels of education. There are some highly educated Asians who are masked in the macro statistics that indicate that the

Asian/Pacific Islander group has relatively low educational attainment. The proportion of high school graduates among Asian-American and Pacific Islander elderly is substantially lower (26%) than among white elders (41%). Some 13% of Asian-American and Pacific Islander elders lack any formal education whatsoever, compared to only 1.6% of white elderly. More than half of Asian elders do not speak English very well. Compared to other ethnic groups, Asian elders are less likely to have at least a ninth-grade education or a college degree.

Income. There is wide variation in income within this group, and there is a bipolar distribution. This group has some of the highest

Figure 3-12
Asian Americans and Pacific Islanders 65+ in California (Percent)



Source: Demographic Research Unit, State of California, Department of Finance, 1998.

income families of all elders in California almost equal to the white population. They also make up a large portion of the poor.

The following descriptions provide a very limited window into the growing group of Asian/Pacific Islander elders.

Chinese-American Elders

Immigration and Migration. Documented immigration from Greater China dates back to the mid 1880s, when Chinese were brought in to build the railroads and for other manual labor. The 1855 State Paupers Act was created to define how to treat their health problems. Immigration was negligible in the first two-thirds of the 20th century because of numerous discriminatory immigration laws. Most Chinese elderly immigrated after passage of the 1965 Immigration Act, which allowed the immigration of relatives of U.S. citizens and permanent residents. Many Chinese elders came to California to live with their children.

Aging and Health Beliefs. Chinese elders have high status and command respect in their families—a legacy from Confucianism that is still very strong today. There is extensive belief in the practice of Chinese medicine, which is widely available in California. There is also an extensive belief system based on foods that is incorporated into daily life. Chinese elders also believe in being proactive to preserve and enhance health in old age. Many practice *tai chi* or *qi gong*.

Social Networks and Family Support.

The center of the social network is the family, although the Chinese also have wide, complicated social networks in the community. Most elders live at home with their spouse or move in with their children as they age or are widowed. Views on family support are changing as the younger Chinese become more acculturated to Western ways, but most children still support their parents.

Population. Chinese make up about 30% of the Asian/Pacific Islander 65+ group in the United States. They are a prominent population in the San Francisco Bay Area. Most are married, and the ratio of men to women is lower than in other non-Asian ethnic groups.

Education. Most of today's Chinese elders have poor educational backgrounds—often only primary school—although about 20% have some college education. The elders speak English poorly as a whole. The English language skills of future generations will improve because the Chinese value education. Language skills will also change as the new, highly educated immigrants to California age over the next 20 years.

Poverty and Income. There is a substantial group of relatively wealthy Chinese. Chinese elders tend to have much lower poverty rates than other non-Asian ethnic groups. They tend to work more after 65 and also live with their extended families, which masks their low incomes and shields them from the effects of poverty.

Japanese-American Elders

Immigration and Migration. Most Japanese-American elders have been in California for some time, and the number of foreign-born elders is smaller than in other Asian groups. There has not been much recent immigration from Japan. Early immigration patterns were similar to other Asian groups because Japanese were brought to California as workers. But the history of the Japanese in California and the United States is unique, given the role of Japan in World War II and the resulting discrimination against Japanese Americans, which included their internment and relocation in 1942. Many of today's elders have vivid memories of this time.

Population Growth and Regional Distribution. The percentage of 65+ elders within the Japanese group is about 13%. The Japanese-American population is now mostly native-born. The majority live in the Los Angeles Basin and San Francisco Bay Area. There are some Japanese communities like “Little Tokyo” in Los Angeles, but the population is distributed throughout many communities in California and is well integrated.

Education and Income. As a group, they are more highly educated and affluent than other Asian groups—few live at or below the poverty line. They are one of the most acculturated ethnic groups in California. Most Japanese elders today speak both Japanese and English, but about one-third do not speak English well. In the future, speaking Japanese will not be prevalent; English has become the

first language in Japanese-American younger cohorts.

Aging and Health Beliefs. The Japanese are long-lived—both men and women. They have the lowest overall mortality rate of all groups of elders. They have strong health beliefs and practices that focus on preventing disease through spiritual, physical, and nutritional actions. Their beliefs are influenced by the Shinto religion and *kanpo*, which emphasize a harmonious relationship with nature. Their diets are low in fat and high in nutrition. The elders do not consume a lot of alcohol. Disease patterns and morbidity vary with location and lifestyle. Incidence of certain kinds of stroke and cancer remain high, but there is much variation within the population. Suicide still occurs at a higher rate than in other groups, and mental illness still carries a stigma.

Social Networks and Caregivers. Although they tend to live with family if their spouse dies, many live alone. As both men and women are long-lived, there are many old Japanese-American couples. Cultural values influence interaction with health providers, including avoidance of shame, difficulty in revealing personal information, deference to authority, acceptance of things beyond their control, and the importance of indirect, non-verbal communication. Japanese Americans are unique among ethnic groups in that they have created special programs and services for their elders, including some nursing homes and special day-care centers.

Filipino-American Elders

Immigration and Migration. The Philippines and the United States have a unique relationship that originated in the 17th and 18th centuries. After the Spanish-American War in 1898, the Philippines was designated a U.S. protectorate and residents traveled on U.S. passports. There have been three waves of immigration during the 20th century. The most recent wave, which began in 1965, has included many well-educated professionals. California and the United States have alternated between deep friendship with Filipinos and discrimination. Because Filipinos served in World War II, they have a special status and acceptance. Today, immigration and migration continues between California and the Philippines.

Population Growth and Regional Distribution. Filipino Americans are the fastest-growing group of Asians, with the largest number of immigrants. In 1998, Filipinos were the second-largest foreign-born population in California. The present cohort of older Filipinos is made up of immigrants, mostly foreign-born and male. Filipinos live in many communities throughout California, with significant populations in San Diego, Los Angeles, and the San Francisco Bay Area.

Education and Income. Filipinos have very low rates of poverty, similar to the Japanese and some Chinese. Many recent immigrants have higher education, and there are many who work in health professions. Extended family systems exist, and they tend to

provide basic support for all members. Being on welfare is not seen as much of an option.

Aging and Health Beliefs. Filipino Americans are very protective of their elders; elders expect their children to take care of them as a way of paying back, or *utang na loob*. Caring for others is a strong cultural value that is learned throughout life, and the family is seen as a health and social service system. Illness is viewed in a holistic framework, with little distinction between physical and mental illness. Filipino-American elders have many beliefs about health, which can include mystical causes. Often, they attribute illness to a very complex array of factors. Their dominant religion is Catholicism, and they believe that suffering and illness are unavoidable conditions. Filipinos have an increased risk for gout, diabetes, tuberculosis, and hypertension, although disease patterns vary among groups depending on a variety of factors.

Social Networks and Caregivers. Even today's Filipino Americans function within an extended family structure with strong emphasis on group and family harmony, loyalty, respect for elders, and maintenance of a family support system. Using formal systems of support is still considered a last resort. The oldest child usually is the decision maker, but other family members also participate. Although family support is still strong, there are tensions in modern Filipino households as members try to balance all the needs of children, elders, and other extended-family members. The extended family includes members back in the Philippines.

AFRICAN AMERICANS

Migration to the West. Many African Americans migrated to the western states in the early 1900s in search of better jobs.

Aging and Health Beliefs. African Americans tend to be pragmatic about aging and see disability as an expected part of the process. They tend to be spiritual or religious and put faith in God.

Social Networks and Family Support. African Americans tend to take on friends and see them as part of the family network. There are many variations of an extended kinship system. African Americans have developed many cultural practices to deal with prejudices and inequalities associated with widespread racism. These include pooling economic resources for survival. African Americans are involved in many intergenerational support activities. Grandparents take an active role in caring for young children, which contributes to a somewhat matriarchal family. They often are extensively involved with churches, both as contributors and recipients of resources. Few utilize nursing homes. There are many older single women, many of whom are childless. Elder women are treated with great respect within the community.

Population Growth and Regional Distribution. The African-American elderly population will grow at an average annual rate of 2.1% between 1990 and 2010. This growth will increase to 3.6% between 2010 and 2030 (see Figure 3–13). In 2010, 55% of California’s African-American elderly will live in the Los Angeles Basin and 27% will live in the San Francisco Bay Area.

Life Expectancy. The life expectancy of African Americans is lower than that of whites, except at advanced ages (75 to 80), when a convergence is observed whereby African Americans have more expected years remaining than whites; this occurrence is called “racial mortality crossover phenomenon.” The existence of a racial mortality crossover at about age 75 is an indication that African Americans and whites age physiologically at different speeds.

Causes of Death. Leading causes of death for African Americans age 65 and older include heart disease, lung cancer, stroke, and chronic obstructive pulmonary disease for men, and heart disease, stroke, diabetes, lung cancer, and colorectal cancer for women.

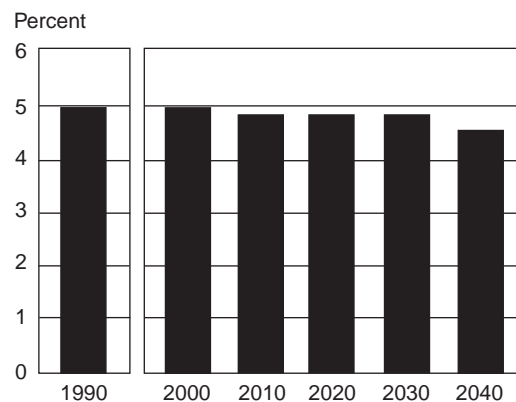
Health Status. Many elder African Americans rate their health as poor. Risk factors that contribute to greater morbidity and mortality among African-American elders include high rates of smoking, poor nutrition, inadequate housing, and reduced access to or use of health care services.

Racism and Discrimination. Discrimination is an important contributor to the high rates of poverty experienced by African-American elders, who often were denied access to jobs commensurate with their experience and capabilities. Moreover, minority elders often were (and still are) paid lower salaries than their white counterparts for the same job responsibilities. Low-wage jobs not only provide less of an income from which to save for retirement, but they are also much less likely to be covered by a private pension.

Caregivers and Family Support. African Americans have histories of strong social support. They tend to welcome friends into their family networks, and these friends provide expressive or instrumental support. African-American families are extremely involved in intergenerational support activities and are likely to treat their elders with more respect than are other ethnic groups. Reciprocally, older African Americans are more likely to take younger family members (grandchildren, nieces, and nephews) into their homes.

Poverty and Income. African Americans have low incomes and are among the poorest citizens. Their job histories consist of low-paying jobs with few benefits and pensions. Maintaining their health is a challenge when out-of-pocket expenses begin to go up.

Figure 3-13
African Americans 65+ in California
(Percent of population)



Source: IFTF; State of California, Department of Finance, Projected Total Population of California Counties.

NATIVE AMERICANS

Population Growth and Regional Distribution. The Native American elderly population is relatively small compared to other minority groups. Some 90% of Native Americans in California are urban dwellers. Most came to California in the 1960s and 1970s under a federal program to relocate them off of the reservations. As a result, the California Native American population is a pan-Indian population composed of many tribes. The elder Native American population will grow at an average annual rate of 5.1% between 1990 and 2010. This growth will decline to 3.7% between 2010 and 2030. In 2010, 32% of California's Native American elderly will live in the Los Angeles Basin, 16% will live in the San Francisco Bay Area, and 16% will live in the San Joaquin Valley region. California's Native American elderly will live in the urban centers of the San Francisco Bay Area and Los Angeles, on rancherias of 30 to 40 houses, and in rural areas of the San Joaquin Valley.

Long-Term Care. Nationwide, from 1980 to 1990 the number of Native American elders doubled. This population growth, coupled with the shift from acute and infectious diseases to chronic and degenerative diseases in this population, is making lack of long-term care the biggest problem Native American elders face.

Chronic Illness. Native American elders tend to experience aging-related physical, psychological, and social changes at much younger ages than do non-Native Americans. The characteristics associated with whites of age 65 often are found at age 55 among urban Native American elders, and at age 45 among elders who live on reservations. Heart disease recently has become the leading cause of death among Native American elders, perhaps as a result of the increasing incidence of diabetes, nontraditional behaviors such as habitual and excessive use of tobacco, and poor dietary practices.

Caregivers and Family Support. Native American cultures have traditionally venerated the value of the extended family. Their elderly historically have been respected for their wisdom, experience, and knowledge of tribal history and customs. Therefore, many elders, regardless of tribe, assumed significant roles as teachers and caretakers of the young. Thus, elders on reservations tend to rely primarily on some form of extended family for caregiving. Those who live away from the reservation—most of the Native American population in California, which has few reservations—cannot rely on these traditions. Because California Native Americans come from many tribes, they have little in common, and traditional social networks are not very functional. Most are forced to try to augment their support through formal resources.

**THE GROWING VULNERABILITY
OF OLDER WOMEN**

A variety of threats and forces make single older women increasingly vulnerable. Older women constitute the majority of the elderly population—particularly those over 85—and they are uniquely vulnerable to poverty and declining health. Already, women who reach age 65 have a life expectancy of almost 19 more years, compared to 15 for men. An astonishing three-fourths of the elderly poor are women. There are currently 57,000 Americans over 100; of those, approximately 85% are women. Women's poverty often begins early in the near-elderly group with the widows gap—which typically occurs between the ages of

55 and 65 when widows lose their husband's income and health insurance. Many women who are younger than their husbands lose health insurance when their husbands become eligible for Medicare at 65.

Although women have an advantage in terms of life expectancy, this advantage is offset by the disability that occurs in this larger population of older women. They experience more years of disability than do men over the age of 65, and their health status is compromised by their role as caregivers for a spouse or older relative. Older women's vulnerability crosses all races but is particularly evident in ethnic minorities.

The average age when a woman is widowed in the United States is 56, yet no Social Security widow's benefits are available until age 60. This discrepancy is called "the widows gap." Even though many women work, few have sufficient income and benefits to support their lifestyle.

In 1995, the median income of men 65 and older was \$16,484, about 76% higher than that of elderly women, \$9,355.

OUTLOOK TO 2010

- Women over 85 will be the most vulnerable subgroup of elders. In addition to the frailty that increases with their longer lives, few women expected or planned for such longevity. They simply will not have the resources to match their longer lives.
- Women of color living in poverty will continue to increase in number. As the ethnic minority populations swell to 35% of the total elder population in 2010, the women among them will continue to slide into poverty. Few will have pensions or savings, and most of their husbands will have relatively low social security benefits that when cut in half will create serious poverty issues.
- More women will be uninsured between the ages of 55 and 65 as the baby boomers reach their mid 50s. California has the highest rate of people without health insurance in the nation, and more than 60% of the uninsured are women. This rate will continue to increase over the next ten years.
- Poor women will find the rising out-of-pocket expenses for health care and other support services impossible to afford, contributing to increased disability because of less-than-adequate care. They will increasingly postpone treatment and care, further exacerbating their health problems.
- Women will occupy more than 65% of nursing home beds, caused in part by their higher incidence of dementia.
- Public policy will not focus on older women's health until the baby boomers begin to retire after 2010.

The Income Challenge

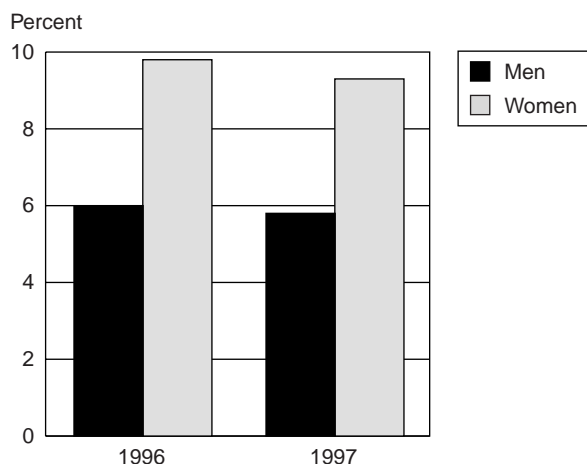
In retirement, older women suffer greater economic risk than men because of income gaps. In 1993, for example, women age 65 and older had a median annual income that was 57% that of their male peers. In 1995, the average Social Security benefit for women was \$538 per month, compared with \$858 for men. Not only are women's Social Security payments less than men's, but such payments are also likely to be their *only* source of income. One in three unmarried older women who receive Social Security depend on it for more than 90% of their income. Only 20% receive private pensions, compared to 44% of men. On average, those incomes are only 50% of men's incomes.

In California, many women will have exhausted their financial and health resources in caring for ill husbands by the time they become widows. And statistics show they might outlive their husbands by five or more years.

Older Women of Color Are Likely to Be Poor

California's elderly women are increasingly divided between wealthier baby boomers, who are more likely to be white, and poorer women, who are much more likely to be women of color. White women tend to have private pensions or other means of augmenting Social Security income. Older women of color are particularly vulnerable to poverty and poor health. African-American and Latino women—who tend to receive lower Social Security payments, based on lower lifetime wages—are more likely to live on public assistance. In 1994, more than twice as many elderly African-American and Latino women were poor than were white women. That same year, 50% of older African-American women living alone were poor (see Figure 3–14). In the coming years, the California elder care system must find ways to address the overwhelming problems of older women, particularly women of color.

Figure 3–14
People 65 and Older Living in Poverty, by Sex,
United States, 1996–1997



Source: U.S. Census Bureau, 1998.

The Health Challenge

Although women make up the majority of the older population, little is known about older women’s health, because research on women has been traditionally underfunded and the majority of health research is still conducted on male subjects. Sadly, older women today experience greater chronic disease and physical limitations than men; they are the vast majority of occupants of nursing

home beds and of elders who need assisted living in their own homes. Researching the health care and social needs of older women is an area of critical importance.

Although women live longer than men and die of the same disorders, they experience greater chronic health problems and physical limitations in their old age.

“Older breast cancer patients receive less aggressive treatment than younger breast cancer patients, although studies have shown them able to tolerate surgery and/or chemotherapy.”

— Deborah Reidy Kelch, *The Health of Older Women in California*

SOME HEALTH FACTS

- Some 80% of older women suffer from osteoporosis. A woman’s risk of developing an osteoporosis-related hip fracture is equal to her combined risk of developing breast, uterine, and ovarian cancer.
- Breast cancer risk increases with age. However more women die of lung cancer than breast cancer.
- Women represent two-thirds of people with arthritis, which affects 57% of women over 65.
- Women are at higher risk for dementia. It is the prime cause of placement in nursing homes.
- Women have higher vision impairment than men, which leads to less functionality in activities of daily living.
- Daily, women take more than three prescription drugs and three over-the-counter medications. About one in four prescription drugs is being given inappropriately and is potentially dangerous.
- Older women represent 67% of residents of skilled nursing facilities and 70% of older home-health users.

Rita, 79, has a group of friends who participate in a walking group three times a week. “One watches the other,” she says, “and we take care of each other. It’s definitely part of staying young to have friends. I miss it on rainy or snowy days when I can’t go walk. I miss my friends. If you ever have problems, you can discuss them with them, and they talk to you. I wouldn’t have someone else to talk to if not for them. My husband died many years ago and most of my older friends have gone.”

— John Rowe and Robert Kahn, *Successful Aging*

The Social Challenge

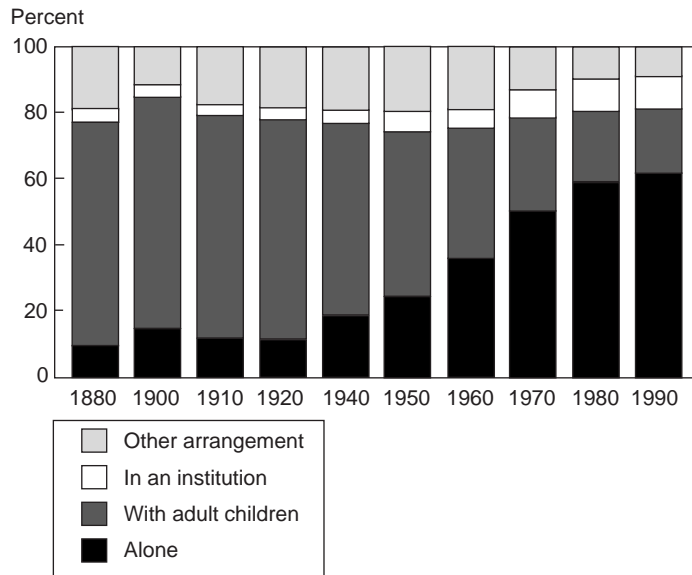
Older women are more likely than older men to live alone, and this likelihood increases with age (see Figure 3–15). Some 40% of women 65 and older (60% of widows) live alone, compared to 16% of men 65 and older. Later marriages, more divorces, and greater longevity also mean that tomorrow’s older widows will have been unmarried for a longer period of their lives (see Figure 3–16).

Successful agers cited in the well-known MacArthur Study report that they tend to

thrive as a result of social connectedness. Women simply live longer when they have strong connections to others. At root, humans do not outgrow their need for each other. Intimate interactions have even been shown to protect people from the damaging effects of stressful life events.

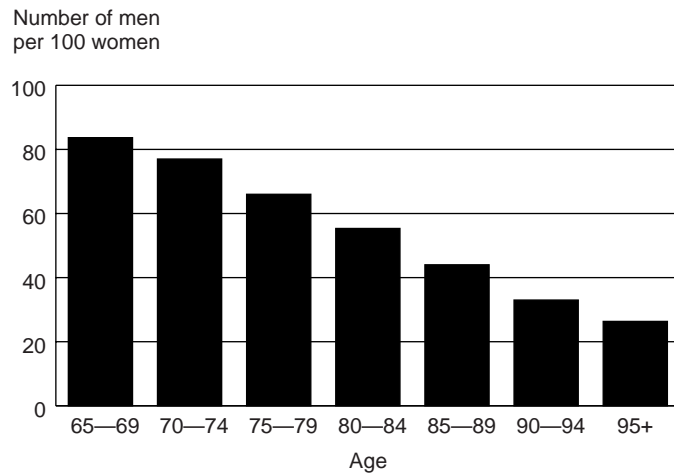
Social support is information leading one to believe that he or she is cared for, loved, esteemed, and a member of a network of mutual obligations.

Figure 3-15
Living Arrangements of Elderly Widows



Source: Economic Report of the President, 1999.

Figure 3-16
Number of Men per 100 Women, by Age, 1994



Source: U.S. Census Bureau, 1994.

5

**ELDER MEDICAL CARE:
FRAGMENTATION OF FINANCING, PROGRAMS, AND SERVICES**

Because California has no organized system of elder care and long-term care delivery, both the financing and the delivery of elder care services are seriously fragmented, resulting in inefficiencies and high costs. Managed Medicare is the dominant form of acute care and is separated from other services. The types of problems facing older Californians today are the same as they were in the 1980s. A patchwork of categorical programs designed to alleviate these problems has instead created a tangle of administrative directives, eligibility issues, turf battles, and duplicated services. Taken as a whole, this disorganized system becomes a formidable barrier, preventing innovative or comprehensive solutions. These systematic problems are further

compounded by a lack of political leadership, which has created a vacuum in policy making. Some observers believe it will take a serious crisis to force public attention to elder issues—a kind of earthquake, to force people to look at the fault lines under their feet and to take the first step in creating a more unified system. In the meantime, the aging agenda languishes, suffering from a lack of leadership, vision, political will, and public attention. These unresolved, long-standing problems have built a gridlock of obstacles.

As of 1999 the U.S. Congress has gone for five years without renewing the Older Americans Act. They have kept it going solely through reauthorization.

OUTLOOK TO 2010

- Little will be done to integrate health services for the elderly. Acute care will remain separate from long-term care, and social services will not be integrated into the continuum of care. California's elders will still lack access to integrated care.
- Elder care will receive little policy focus in California. The state will not become a leader or innovator in care of the elderly.
- Private long-term care insurance coverage remains low and insufficient to cover most needs; it will not play a significant role in financing care.
- Long-term care continues to shift to the home and the community and long-term care issues remain largely ignored
- Expect small amounts of budget augmentations for elder programs at the state level. California will remain very low in spending per elder (currently \$7 per elder) as compared to other states.
- Innovative pilot programs, such as the Program of All-Inclusive Care for the Elderly (PACE), that care for the elderly will be replicated, but to an insignificant degree. State funding priorities remain a barrier.
- Medicare and Social Security systems will receive continued tinkering but no major overhaul. A drug benefit will be passed early in the 21st century and copayments will rise.
- The federal government, beyond providing Medicare, will continue devolving responsibility to state and local governments.
- The chronic lack of physicians and other health care workers trained in geriatrics will persist; the gap between need and provision will widen further.
- Few ethnically specific services exist. Many cultural and linguistic barriers will remain.

FORECAST FOR MEDICARE MANAGED CARE—2005

- Increasing but slowed growth (more than 46%, or 2,060,000, by 2005) in enrollees. Drug benefit legislation could be a brake on enrollment in Medicare managed care because elders could get this covered under regular Medicare.
- Elders will continue to find the Medicare managed care option desirable because it is less expensive than traditional Medicare with supplemental Medigap insurance. Health care benefits that include drug, dental, and vision coverage will attract the elderly.
- Medicare managed care enrollees will assume more out-of-pocket expenses for services (especially for drugs, copays, and deductibles) as health plans shift more cost to patients in an effort to remain profitable. Those elders on fixed incomes will find this shift a difficult burden.
- Rural regions of the state, particularly in Northern California, will find it difficult to enroll in a managed care program. Health plans simply will not be able to make a managed care option available in sparsely populated or geographically dispersed areas of California. These populations are too small for a risk pool and the reimbursement too small to make a profit. Frail and disabled elders in these areas will be particularly at risk, because even the option of buying supplemental insurance may not be available.
- Medicare managed care enrollees will continue to experience disruptions if health plans pull out of the market or adjust their product to remain profitable.

LONG-TERM CARE FORECAST TO 2010

- Consumers will demand alternatives to nursing homes.
- Experiments in managed long-term care will increase, driven by rising costs.
- Few integrative long-term care programs will be available before 2010.
- Sales of private long-term care will slowly rise, encouraged by new federal tax incentives. Private long-term care, though, still will not be a major player and will remain at around 5% to 7% of long-term care costs. The rest will remain publicly financed.
- Long-term care policies will begin to provide benefits for functional and cognitive impairments.
- Large health plans need incentives to innovate in chronic care. If there is a significant change in the risk adjustment formula, there will be some innovations.

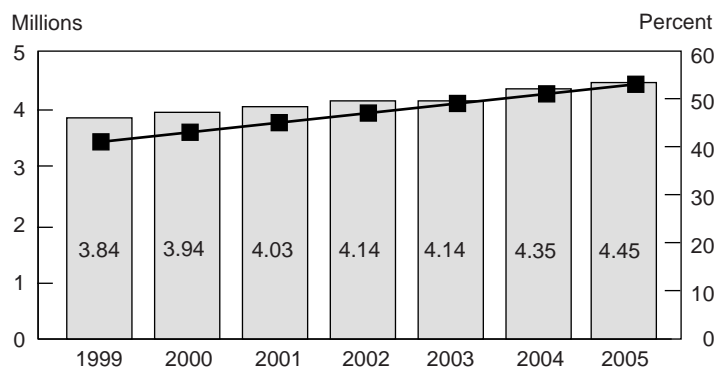
The Continued Rise of Managed Care

California has led the nation in the adoption of Medicare managed care. Medicare managed care penetration grew from 9% in 1989 to 39% in 1998 and will exceed 50% by 2005, with over 4.4 million medicare beneficiaries enrolled (see Figure 3–17). This growth will continue, despite withdrawals of several plans from some California counties in 1999, which left only 38 of the state’s 58 counties with managed Medicare. Medicare managed care plans attract lower-middle-class and low-income elders because they result in financial savings—fewer copays, lower deductibles, and enhanced benefits such as vision and prescriptions. These plans must take all comers; they cannot screen out certain elders for medical or other reasons.

Frail Elderly and Health Maintenance Organizations

As more older Californians become members of HMOs, they will begin to raise questions about the suitability of managed care for the frail elderly and others among their cohort. HMOs, like the rest of the health care system, are set up primarily to treat acute medical problems. Yet the care of elders will require extensive treatment of chronic illness and other sorts of long-term care, with the goals of curbing costs and maintaining healthy bodily and mental functioning, not merely preserving and prolonging life. In short, to treat aging baby boomers and elders of the future, HMOs will have to shift their focus and begin to provide *maintenance* of health throughout the cycle of their members’ lives, just as their name suggests. Unfortunately, there are few incentives for large health plans to innovate. Addressing the need for new risk adjustment would help, but other barriers remain, such as the lack of geriatric training and the medical culture that has always found chronic care unappealing.

Figure 3–17
Growth in California Medicare Market, 1999–2005



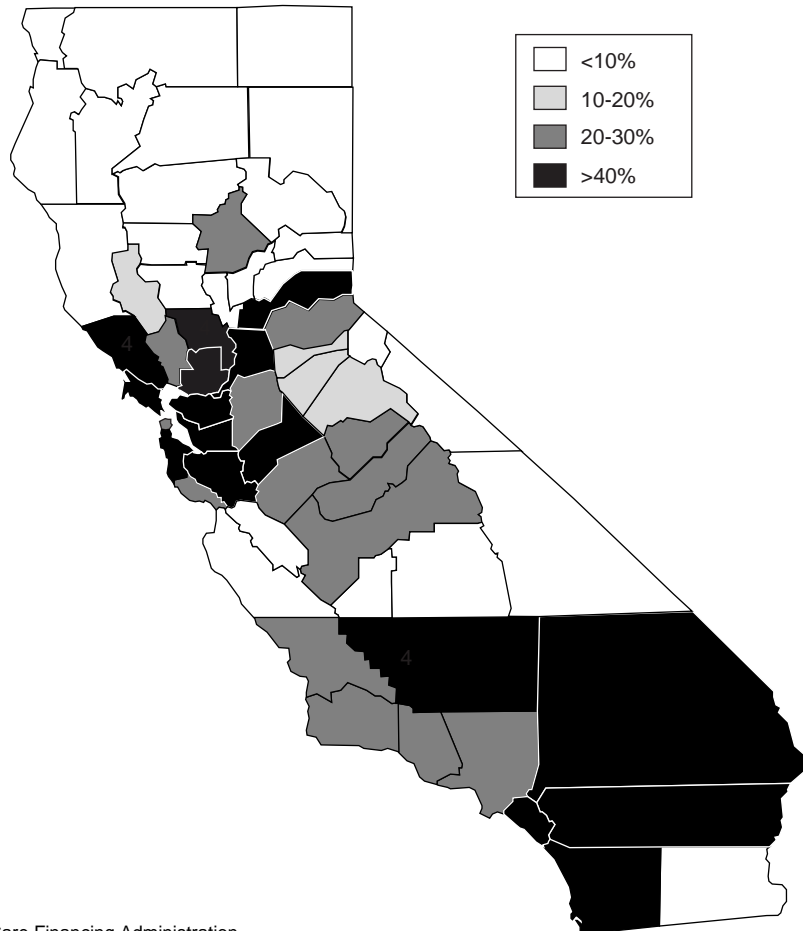
Source: IFTF; Health Care Financing Administration, 1997.

**Medicare Managed Care
Varies Widely**

The penetration of Medicare managed care varies widely across the state's counties and metropolitan areas (see Figure 3-18). Although some counties in Southern California have now reached Medicare participation rates of more than 70% and will see slower growth, there is still plenty of opportunity for plans to enroll elders in the northern and central parts of the state. Hospitals and specialists who

serve the elderly will come under considerable pressure, because elders in HMOs use dramatically fewer services than those in fee-for-service Medicare. Similarly, health-conscious baby boomers, who are only about a decade away from starting retirement and Medicare eligibility, will be important indicators for those who track managed care delivery.

*Figure 3-18
Managed Care Market Status, 1999
(Medicare managed care penetration by county)*



Source: IFTF; Health Care Financing Administration.

Enter Disease Management

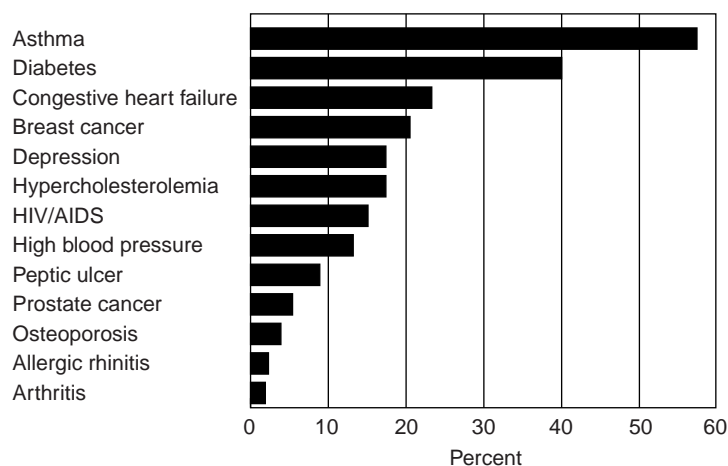
In today's cost-conscious health care environment, disease management has emerged as an important strategy for managing the high costs of chronic conditions. Indeed, some observers of the health care industry view disease management as the next step in the evolution of managed care, particularly because it emphasizes prevention, promises better health outcomes, and saves costs.

The underlying philosophy of disease management is powerful. By catching a disease early in its life cycle and using an integrated set of tools, processes, and interventions, providers can optimally manage

patients, prevent acute episodes of their chronic disease, and avoid care in high-cost settings such as hospitals. Given the imperative for cost containment that characterizes the U.S. health care system today, it is no surprise that managed care organizations are implementing disease management programs, in various forms, across an entire range of chronic diseases and illnesses (see Figure 3–19). As a result, a wide range of companies has emerged—from entrepreneurial start-ups to programs within larger managed care organizations—that manage diseases all along the continuum of care.

Disease management may ease the health and economic burden of chronic disease. The number of people with chronic conditions is expected to increase by 14% in the next decade, from 105 million in 2000 to 120 million in 2010. That growth translates to a full 40% of Americans living with chronic conditions by the year 2010. Direct medical costs for persons with chronic conditions will increase by 16% in the next decade, from \$503 billion in 2000 to \$582 billion in 2010. These trends are alarming; however, the onset of many of these diseases and their attendant complications can be delayed and in some cases completely avoided. As long as cost reduction remains the principle driver of change in the health care system, disease management will be provided by, purchased by, or created by whoever is paying the bill for health care or is at financial risk for the cost of health care.

*Figure 3–19
Managed Care Organizations Embrace Disease Management
(Percent of HMOs that have implemented disease management programs for the following conditions)*



Source: Interstudy, Interstudy Competitive Edge, HMO Industry Report 1997.

**The Long-Term Care
Conundrum**

People tend to think of long-term care as synonymous with nursing homes, but it is far from that. Fundamentally, it is a very complex issue, involving a whole range of diverse services provided formally and informally in the community and at home by both professionals and family members. It is also a big “values” issue, because it tells us who provides such care and how we care for dependent people in California. For the most part, long-term care has been poorly con-

ceived, funded, and managed. At root, California has no system of long-term care delivery, and public policy on the issue remains fragmented and insignificant.

The growth of the oldest old (85 and older) will drive the need for long-term care. The relentless growth of this population during the next ten to 20 years will outstrip the state’s planned resources because, in all probability, the growth of the 85+ population already is underestimated.

“Long-term care means a coordinated continuum of preventive, diagnostic, therapeutic, rehabilitative, supportive, and maintenance services that address the health, social, and personal needs of individuals who have restricted self-care capabilities. Services shall be designed to recognize the positive capabilities of the individual and maximize the potential for the optimum level of physical, social, and mental well-being in the least restrictive environment. Emphasis shall be placed on seeking services alternatives to institutionalization. Services may be by formal or informal support systems and may be continuous or intermittent. ‘Long-term care’ may include nursing facility, adult residential care, residential facility for the elderly, or home and community based services.”

—Welfare and Institutions Code, Division 8.5,
Section 9016

Almost 13 million Americans have chronic problems that require ongoing assistance—a constant and costly demand on a health care system that was never designed for prevention and maintenance but instead for identifying illnesses, treating symptoms and sometimes producing cures. The result of this mismatch between need and design is that people often go without help, face conditions that deteriorate prematurely and sometimes are pressed into high-cost institutions before necessary. As the baby boom moves into its declining years and begins to balloon the elderly population, the pressure is building to change the approach to long-term care.

—The California Little Hoover Commission,
*Long-Term Care: Providing Compassion Without
Confusion*, December 1996

SOME STICKY ISSUES

Chronic and Acute Care Funds Are Divided

At the federal and state level, health care programs for the elderly are divided between acute care, financed by the federal Medicare program, and long-term care programs, funded mostly by the state's Medi-Cal program. This division results in powerful incentives for both levels of government to shift costs to the other, which often involves the costly "medicalization" of social needs, discontinuity of care, and the failure to provide the least costly and clinically appropriate care (see Table 3–7). Medicare, for example, provides better acute care coverage than long-term coverage. Medicare does not cover prescription drugs and long-term care services, the two aspects of health care most needed by elders with chronic illness. This funding split

can lead to medicare fraud and also creates incentives for premature institutionalization instead of appropriate home or community-based care, because of prioritized state funding for skilled nursing care.

Long-Term Care Costs Are Rising, and Services Are Fragmented

Long-term care eats up 16% of Medi-Cal's budget but serves only 1.3% of its enrollees. Consumer choice, individualized care plans, and appropriate levels of care are often unavailable. While many federal, state, and local programs offer medical and social support, they suffer from gaps and duplications, and they give short shrift to individual consumers who often prefer long-term care at home.

*Table 3–7
Financing Elder Care: Fragmentation and Rising Costs*

Aggregate Expenditures

- California state government services for elder care are budgeted at roughly \$2 billion a year, including both direct health services and supportive services (such as nutrition and caregiver programs).
- Medi-Cal provides roughly \$3.5 billion a year for long-term care services, most of which are for the elderly.
- California's elderly and others who depend on long-term care spend another \$4.4 billion in out-of-pocket expenses.
- Total Medicare spending in the state (86% of which is directed to elders) totals more than \$17 billion; most of this is for hospital and physician costs and long-term care.

Source: IFTF; *California State Budget*, 1997.

A History of Failed Integration Initiatives

In 1980, long-term care funds and programs were conceptualized at all levels of government, but many of the plans were never acted on. Ever since, efforts to consolidate long-term care have foundered, largely because of infighting and philosophical differences between state and local authorities. Ultimately, most advocates recognize that California needs a single access to all health and social long-term care services.

Growing Demand for Community-Based and Home Care

Some 103,000 Californians live in nursing facilities (a figure that has remained stable during the 1990s), but “board-and-care” facilities (nonmedical residential homes) have grown by 36%. Home health is also expanding rapidly, growing 16% each year throughout the 1990s. Nationwide, home care now demands 3% of health care costs. In

California in the late 1990s, home health came under scrutiny. Growth in home health care has now plateaued.

Many Pilot Programs, but Few Long-Term Impacts

Some pilot programs integrate, manage, and organize funding for California’s elder care (see Table 3–8), like the On Lok Senior Health Services program in San Francisco and PACE. Such programs combine acute and long-term care in a capitated, community-based model that stresses case management and continuum of care. Unfortunately, the diffusion of these innovations remains stagnant while the model remains in practice only in a few locations. The authorization of the PACE Program in 1997 as an option for all 50 states was the first medicare funded option since Hospice was authorized 17 years ago in 1980.

**FIVE FACTORS SHAPING
LONG-TERM CARE TO 2010**

- Increased competition and sicker nursing home residents
- Industry consolidation
- Government rule changes
- Increasing the quality in nursing homes.
- Managing rising costs and paying for services
- Long-term care policies that support common sense needs, such as loosening requirements for HUD housing where elders aging in place live.

Table 3–8
Long-Term Care Demonstration Projects

<i>Name</i>	<i>Description</i>	<i>Year Started</i>	<i>Sites</i>
Multipurpose Senior Services Project (MSSP)	<ul style="list-style-type: none"> Provides comprehensive case management to frail elderly people to help them remain at home. People over the age of 65 who are certifiable for nursing facility placement based on Medi-Cal criteria, and who are Medi-Cal eligible, are eligible for MSSP. 	1977	<ul style="list-style-type: none"> 22 sites serving approximately 6,000 clients month.
Program of All-Inclusive Care for the Elderly (PACE)	<ul style="list-style-type: none"> National project to replicate the successful On Lok Senior Health Services program in San Francisco, a Medicare/Medi-Cal managed care program. Comprehensive program providing complete community-based acute and chronic care services to frail elderly participants. Assumes full risk for the costs of both acute and long-term care services in exchange for flat-rate payments from Medicare and Medi-Cal. The Balanced Budget Act of 1997 established PACE as a permanent type of provider under Medicare and allowed states the option to pay for PACE services under Medicaid. The number authorized increased from 15 to 40 programs, with an additional 20 programs authorized each succeeding year. 	1973–1990	<ul style="list-style-type: none"> On Lok (San Francisco). Congressional authorization for ten demonstration projects built on federal Medicare and Medicaid waivers (authorization later increased to 15). As of September 1998, there were 14 PACE programs in ten states, including three in California—On Lok Senior Health Services in San Francisco, Center for Elders Independence in Oakland, and Sutter Senior Care in Sacramento.
Social HMO (SHMO)	<ul style="list-style-type: none"> Expands comprehensive HMO benefits to include community-based long-term care and some nursing home care 	1982–1993	<ul style="list-style-type: none"> Nine sites nationwide; California has one SHMO, in Long Beach, which serves 6,000 people as part of a licensed health care service known as SCAN Health Plan.
Mello-Bates Long-Term Care Integration Project	<ul style="list-style-type: none"> Pilot programs will integrate financing and services, eliminate duplication, and provide a continuum of health support services, including both institutional and home/community-based programs. Pilots may vary from county to county, but each will include a single administrative structure and service delivery system. 	1995	<ul style="list-style-type: none"> Five counties (note: this program is not fully implemented).

Source: IFTF; Deborah Reidy Kelch, *The Health of Older Women in California*, June 1996.

6

**THE HOUSING CHALLENGE:
A GROWING NEED FOR SENIOR HOUSING AND COMMUNITY-BASED SERVICES**

For many years, experts in the aging field have warned of a looming crisis in housing. By most estimates, that crisis has arrived, creating the most severe short-term problem currently facing California elders. The issue is a complex one. One weighty issue is how to best support the services frail elders need when they require more than their own home and less than a nursing home.

One key challenge is coming to grips with the costly choice of adding services to public or subsidized housing for those elders who are aging in place. Housing for elders has always been mixed up with housing for the poor. A second challenge is the dilemma of whether to authorize some or all services to residential care facilities. A third challenge

revolves around the level of services assisted-living programs should be licensed to deliver for their residents. A fourth dilemma revolves around the very high cost of housing in California and how best to support elders living in their own homes as long as possible. There is even a concern that California could see an increase in homeless elders given the current gap between needs, income, and available solutions for those in low-income groups.

There has never been a comprehensive state housing policy to serve as a decision-making framework. There are few innovations at the federal level, although the federal government did propose a voucher system for private housing as a solution to some problems.

OUTLOOK TO 2010

- California needs a comprehensive public policy framework but it is unlikely that one will emerge in the next ten years. Policy will remain fragmented, slow to respond to needs, and unwilling to support housing innovations. Watch for workarounds to existing policy, such as residential care facilities (RCFEs) forming separate companies so that they can provide their residents with home health services. There is some possibility that women politicians will begin to focus on the challenges faced by older women by 2010. However it is unlikely they will have much clout to pass major legislation. Look for tinkering around the edges.
- HUD will continue to try to get out of the housing business. The aging in place of low-income near-elderly and disabled Californians will demand many changes be made to accommodate their support needs as elders. Adding medical services to housing is very costly and is a long-term commitment. HUD will actively look for private solutions, with few takers. It is likely that some government solution will be put in place by 2010.
- Demand for assisted-living housing will grow, driven by people 75 and older. Most of these people will be surviving spouses who are unable to shoulder the financial and physical burden of home ownership. Few new solutions will come about until a crisis stage is reached—well into the retirement years of boomers
- Expect at least a few horror stories as some housing operators attempt to provide more than they are capable of doing. Many will be driven to try workarounds in the current nonsensical restrictive environment. Some won't work. The lack of effective policy and regulation will allow some abuses, however intentional or unintentional, to occur.
- Look for experiments among the young old and the oldest old to address housing and living needs. Arrangements such as shared housing and portable elder cottages in their children's backyards will be just a few of the innovations.
- Housing costs will rise above 50% of income for California's "have-nots": single elderly women, Latinos, and African Americans. Many will look to families for housing. However there is a changing culture around care of the elderly across all cultures. Look for many to continue to live alone or move to low income housing for elders as close to families and social networks as possible.

**Aging in Place in Housing
and Urban Developments**

Some 150,000 elderly now live in senior housing projects. These facilities were built in the 1970s and 1980s, and attracted the younger old, who are now moving into the oldest-old category. Many have been living in these facilities for more than 20 years. These projects need to transform themselves into assisted-living facilities to support this group's aging in place. Many dilemmas, however, are preventing this transformation, including regulatory barriers, no source of reimbursement, no concept of a service package within HUD, and lack of service coordination, among others.

**Poor Elders Face the
Biggest Challenges**

Despite the state's 800+ senior housing projects, assisted-living housing for poor elders is in critically short supply. State data show that half of all residents of senior housing projects live below the poverty line, 73% of the residents are women, a large proportion are minorities, and the majority live alone (see Figure 3–20). Despite the need and preference for assisted living, most senior housing projects are simply unable to provide services necessary to support continued independent living by their residents because of outdated regulations. Assisted-living programs offer the advantage of lower costs than institutional care, as well as greater freedom and empowerment for elders—a seemingly win-win common-sense solution to a critical problem.

SENIOR HOUSING PROJECT TRANSFORMATION: PERSISTENT BARRIERS

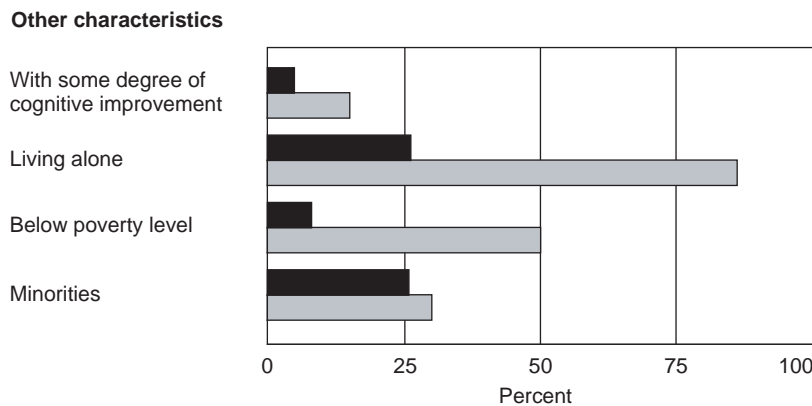
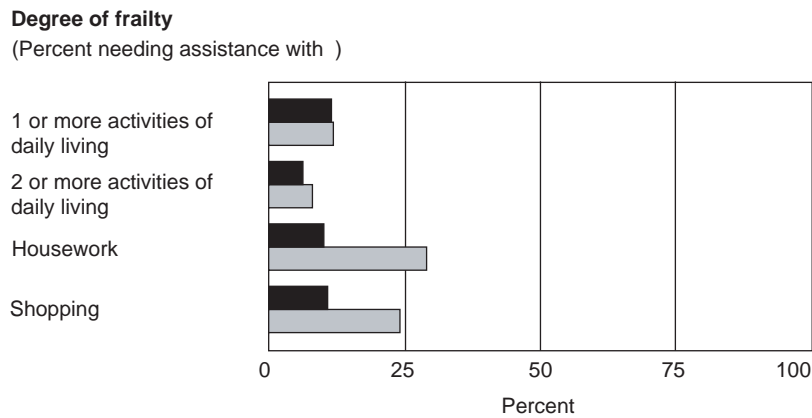
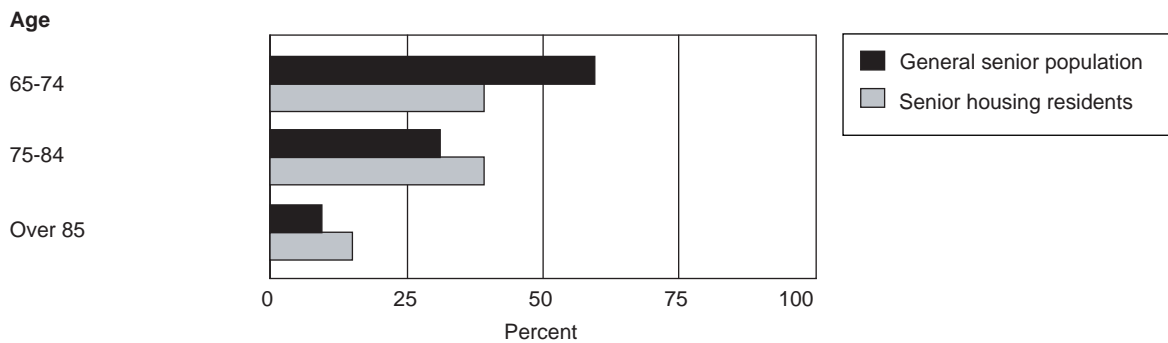
- Government is very reluctant to add medical and health services to housing because of cost.
- Senior housing residents have limited access to community-based services, because of constrained funding, capacity limitations, fragmented programs, and lack of targeted programming.
- Limits on federal housing funds for supportive service: senior housing projects depend on their own operating revenues and local funds to finance needed services and improvements.
- Lack of integration of housing and supportive services: programs are stretched among several departments and levels of

government, without central integration or coordination.

- Senior housing residents are unable or unwilling to pay for supportive services. Many are low-income, and participation in services is optional, creating inefficiencies of scale.
- Uncertainty over what types of services or activities senior housing projects can undertake without violating licensing standards. Such rules create disincentives for projects to offer services to tenants.
- A lack of construction funds means building cannot keep pace with growing demands for senior housing.

Source: California Senate Office of Research, *Beyond Bricks and Mortar: Issues Facing Senior Housing in California*, March 1993.

Figure 3–20
Senior Housing Residents Are Poor, Predominantly Women and Minorities, and Live Alone
(Senior housing residents versus elders in general, California)



Source: California Senate Office of Research, *Beyond Bricks and Mortar, Issues Facing Senior Housing in California*, March 1995.

THE PUBLIC POLICY NEEDS

- Put in place a comprehensive California housing policy framework.
- Loosen regulations to allow HUD low-income housing residents to age in place. Adapt them and add services. Limit this to current residents and provide new innovations for new residents who are younger.
- Separate housing for the poor from housing for elders.
- Change current reimbursement that favors medical and skilled nursing institutions.
- Modernize regulation and financing of assisted living, including decisions on inclusion of medical services. Make assisted living affordable.
- Resolve consumer protection with common-sense policies. Do not overregulate an emerging market of residential care facilities.
- Develop new codes relevant to assisted-living facilities, not nursing homes.
- Decide what to address with public policy and what to leave to others.
- Facilitate the relationship between managed care and assisted living.

“In the years ahead quality, accessible assisted living settings will become a central source of care for elderly Americans. This projected growth has caught the attention of financiers, Wall Street and policymakers.”

—The National Center for Assisted Living

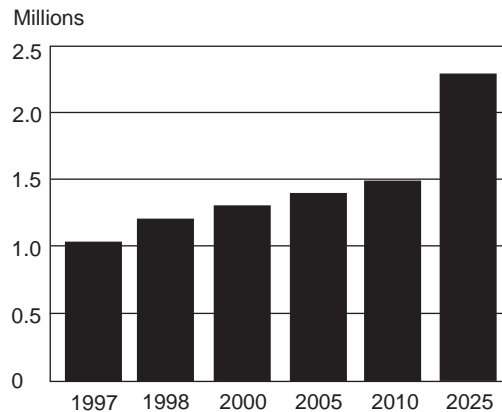
**Assisted-Living Programs in California:
More Support Needed**

About 150,000 Californians live in assisted-living programs in California. The average age of the residents is 83.

The trend toward assisted living is changing views of the full continuum of care. As more people live to be 85 and older, they will want to stay at home as long as possible; and most people need something in between their own home and a nursing home. Many studies have documented the advantages of caring

for frail elderly and handicapped people in residential rather than institutional settings. The cost of caring for elderly residents with comparable support needs in congregate housing projects is significantly lower than that of institutional long-term care facilities. However, there is political and medical resistance to adding some level of medical services to support ongoing needs. In some cases medical waivers are required (Figure 3–21).

*Figure 3–21
Number of Residents in Assisted Living, United States*



Source: National Center for Assisted Living, 1999.

**Residential Care Facilities:
Even Elders with Money Face Challenges**

Residential care facilities, even for those with money, are in short supply. But new projects are being developed for middle- and high-income elders, costing \$2,000 to \$3,000 per month.

**Aging in Place
Comes in Many Forms**

Older people want to stay at home, or at least in a homelike situation, as long as they can. This desire will result in many shifts and experiments over the next ten or 20 years. Decision makers and policymakers need to do everything they can to support elders living in their own homes and communities.

Shared Housing

Elders who wish to remain independent—to reduce economic, physical, and social loss—can do so through shared housing. Shared housing is defined as two or more elders who live together to pool resources or to share common spaces like kitchens and bathrooms. This living situation provides the benefit of additional income, companionship, security, personal services, and opportunities for emotional, social, and physical support. People who live in shared-housing arrangements may face zoning and landlord-tenant issues, and some may even lose government assistance, such as Social Security and food stamps, or face an increase in taxes or insurance. Although the concept of shared housing is not new, it will likely grow as an alternative over the next 20 years as people, women and widows in particular, live longer and their funds dwindle.

**Neighborhoods and Communities
Strategize for Elders**

In the long run, more elders and their neighbors will learn how to maintain their communities. Neighborhoods are “naturally occurring retirement communities” (NORCs).

Aging is just as much about place as time. The sheer size of the aging population will slowly see the conversion of many neighborhoods to elder-friendly places. As people begin to think differently about aging, they will learn how to provide security, build social networks of support, and keep long-term neighbors in place. A movement to in-fill housing for neighborhoods with space is also likely. Designs and financing for senior housing in existing neighborhoods will occur. Eventually, new communities will include designs for elders as part of the mix.

Adapting Your Own Home

New ideas, tools, and technologies are being devised to allow elders to make their homes better fit their needs. There are a plethora of new companies aimed at equipping homes to support aging in place. These include everything from security systems to kitchen and bathroom remodels to different elder-friendly home appliances. Although major upgrades will be unaffordable for most elders, there will be many affordable items quite useful to all.

THE CAREGIVERS' CONUNDRUM

Who will care for this growing number of California elders, especially as they move from young old to oldest old, and slowly become more frail? Are California communities aging-friendly? These are the questions that set the context for the caregivers' conundrum.

Contrary to perceptions that the elderly are usually abandoned by their families, most families in fact continue to care for them. Indeed, about 80% of care is provided by family, friends, and neighbors. Such care provision is very much the role of families and local communities. But the question of who will provide this care in the coming years is becoming an urgent concern in California, as the number of the oldest old will grow over

the next two decades and as the scale of caregiving needs skyrockets. The caregivers themselves are becoming older and more frail. And the number of family members available to provide care is declining: more women are working, families are smaller and geographically dispersed, and single women head many California households that include older people. Although more services are becoming available in some communities, they are fragmented. As a result, families seeking help must run through a maze of uncoordinated health and social programs, and they often get lost or simply give up. All types of aging facilities are facing a crisis in the lack of available workers for paid caregiving positions.

OUTLOOK TO 2010

- Women will continue to leave their traditional roles and hire caregivers for their aging parents. However, the lack of available paid caregivers will reach crisis proportions over the next ten years.
- Cultural clashes between white elders and ethnically diverse caregivers increase in all facilities. New programs are initiated in some, but the majority ignore the problem.
- The two-elderly-generation support ratio, calculated by the number of people 85 and older per 100 people 65 to 69, will increase steadily (see Figure 3–22). The burden of the youngest old (65 to 69) in caring for the oldest old (85+) will grow substantially over the next several decades.
- Overall, the support ratio of caregivers to elderly will remain stable until 2010. However, the old-age support ratio of caregivers to cared-for will increase about 70% between 2010 and 2030.
- Public policy will remain fragmented and piecemeal. About 75% of caregiving will be done informally by families. Because the true intergenerational issue of a rapidly diminishing caregiver ratio is still more than a decade away, it will be hard to get government attention even though respite care and better information is a critical public issue. Although new tax policies and augmentation of the Family Leave Act are needed, there is little advance on the issue.
- Home and community-based services will continue to be inadequate to meet the growing needs of elders.
- The Internet will provide new, vital connections between families and elders, and their caregivers and services.
- Look for women to take on this (traditionally) women's issue. Women will begin to speak out more effectively. Given the stressful demands on women caregivers, they are likely to begin to organize support from society and their employers, or to seek help in meeting these diverse, overwhelming sets of responsibilities in innovative ways.

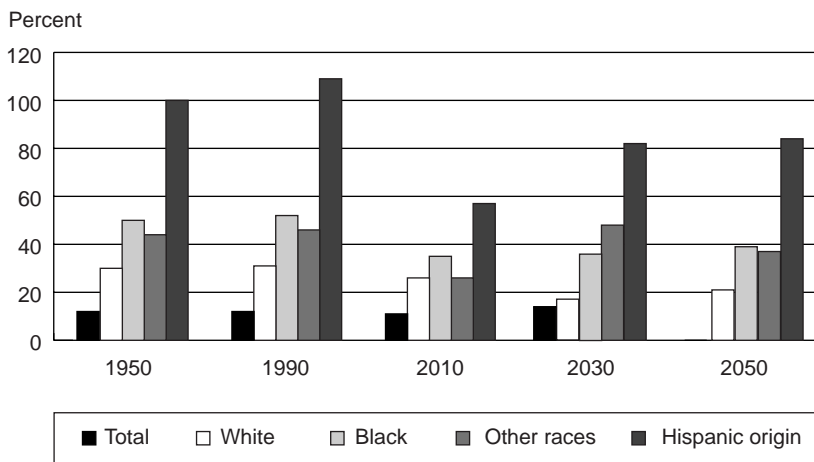
Informal Caregiving Is the Primary Source of Long-Term Care

Three-fourths of frail and disabled older people receive their care from families and friends. Only about 14% of home care is provided by paid caregivers, and more than 80% of caregivers (paid and unpaid) are women. Some 75% of these community (unpaid) caregivers are women: wives, daughters, and daughters-in-law of the older person needing care. Yet in California, most women work full time and also take care of children and household functions (studies show that men still contribute less than women to work in the home, despite many decades of women being in the workforce). An estimated 43% of

family caregivers under 65 juggle work, child care, and caregiving in the Golden State. These individual caregivers experience significant stress, because they are caught between the demands of work, care for dependent children, and the needs of the aging relative (see Figure 3–23).

An increasing number of older people are providing care—to spouses, parents, and other family members—even though they are nearly as frail as those they are taking care of. This phenomenon is becoming more common and is of great concern to experts within the field of aging.

*Figure 3–22
Two-Elderly-Generation Support Ratios, 1950–2050
(Ratio of people 85+ to people age 65 to 69 years)*



Source: IFTF; U.S. Census Bureau.

**Middle-Aged Women:
Caregivers Are at Risk**

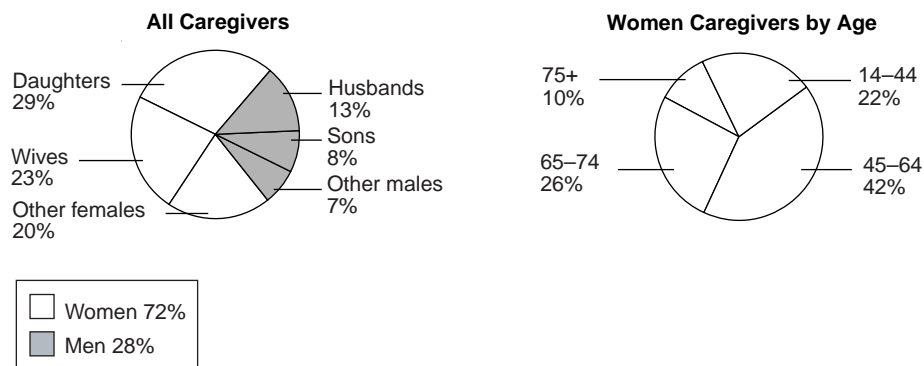
A survey of caregivers of brain-impaired adults conducted by California's Caregiver Resource Center from 1990 to 1992 found that:

- 76% of caregivers were female
- The mean age of caregivers was 59 (range of ages was 17 to 94)
- 75% lived with the patient
- 32% worked (47% of those under 65 worked)
- Of those who had been in the labor force, 18% had to quit their jobs to give care

- 70% said the patient could not be left alone
- The mean number of hours caregivers provided was 93.3 per week

The “sandwich generation”—women caught between the responsibilities of raising a family and taking care of aging parents—can send their children off to school and change jobs if they need to, but they have few options for taking care of aging parents. It's hard to predict when the parent's health will fail, and the caregiving can last a very long time—even decades.

Figure 3-23
Most Caregivers Are Middle-Aged Women



Source: Robert Wood Johnson Foundation, *Chronic Care in America: A 21st Century Challenge*, August 1996.

The Supply of Informal Caregivers and the Shift to Paid Caregivers

At the dawn of the 21st century, California is experiencing a crisis from the lack of available workers to fill paid caregiver positions. This situation will continue to worsen over the next ten years, and there are no easy solutions.

The supply of family caregivers will decline as the baby boom generation retires, because the group has fewer children (see Figure 3–24). The number of elderly people for every 100 adults of working age will increase as baby boomers age, from 20 elderly

for every 100 working-age adults in 1990 to 32 elderly per 100 in 2025. Gerontologists expect a shift to paid caregivers over this period; trends show that older people increasingly prefer to live independently of children and relatives, and one-third currently live alone.

Culture Clash: The New Ethnically Diverse Caregivers of the Older White Population

Increasingly, paid caregivers of older white Californians are young members of ethnic minority groups. Demographics show that for the next decade, most of the oldest-old and chronically ill elders will be white. Already, elders and ethnically diverse caregivers are confronting serious language and communication gaps—problems exacerbated by the poor training and orientation that these poorly paid service workers receive. Although there are some facilities that are instituting training, much more is needed. There are many little things that cause problems, such as white elders becoming needlessly paranoid when Latino staff speak in Spanish.

*Figure 3–24
The Shrinking Pool of Potential Caregivers*



Note: In 1990, the ratio of the population in the average caregiving age range, ages 50 to 64, to the population age 85 and older was 11 to 1. By 2050, it will be 4 to 1.

Source: Robert Wood Johnson Foundation, *Chronic Care in America, A 21st Century Challenge*, 1996.

**Who Supports
Caregivers?**

Has informal caregiving become a substitute for a comprehensive approach that provides financial protection against the costs of long-term care for every family, whether that care is provided at home, in the community, in a residential care setting, or in a skilled nursing facility?

**Caregiving Impacts the Physical, Mental,
and Financial Well-Being of Caregivers**

Caregivers are more likely than their peers to report themselves in poor health. They have less time to devote to leisure pursuits, they take no vacations, they spend less time with other family members, and they even reduce their paid work to perform their caregiving chores. They are also more likely to report adjusted family incomes below the poverty line.

The Pressures and Costs Are High

Working adults experience difficult financial demands when providing for their children, caring for their elders, and planning for their own retirement. They also face stressful choices such as whether to pay for their children's education (helping them to ensure a bright future) or to care adequately for an aging parent. Most are forced to pay for elder care, leaving their children vulnerable—and society potentially weaker, with a less-educated workforce.

**Caregiving Impacts
Workforce Participation**

Caregiving can even have a dramatic impact on a person's ability to work responsibly. Across several studies, about one-third of employed caregivers report losing time from work, many take early retirement if eligible, and some simply give up their job if the burden becomes too much. In fact, approximately 20% of today's workforce spends about ten hours a week caring for an elderly family member.

**Few Public or Private Programs to
Assist Caregivers**

Organized public or private programs that provide support and respite to caregivers of California's elders are few and far between. Family caregivers typically seek help only at a crisis point, and many find they must place their loved one in a nursing facility—often at public expense—because the absence of supportive services has made the caregiving burden unbearable. The Internet is providing some relief as more online information services become available. This makes information in one community accessible to distant family members.

Will There Be Generational Tension Over Resources?

The growth of the state's aging population may result in new tensions between older and younger generations, with an ethnic twist. In effect, a young and ethnically diverse workforce will be asked to assume increasingly heavy financial burdens to support a growing number of white, middle-class retirees. Age will significantly affect dependency ratios: that is, the number of people under 18 and over 65 per 100 people age 18 to 64. California already has a higher ratio of total dependency than the nation as a whole (see Table 3-9).

The Rise of Community-Based Services

In the past few years there has been a welcome increase in community-based services for older Californians. Some of this has been driven by the Older American's Act, which provided every state with some money to begin to coordinate (through Area Agencies on Aging) and help with the development of services. However, this area is underfunded. Services range from legal services, employment services, meals on wheels, adult protective services, ombudsmen, and so on.

*Table 3-9
The Battleground Ahead
(Children versus elders)*

<i>Children</i>	<i>Elders</i>
<ul style="list-style-type: none"> • 28.6% poverty rate • Increasing Latino population • Increasing numbers of uninsured • Need schools and better education • 10% decrease in household income among since 1973 • Increasing dropout rates and functional illiteracy rates 	<ul style="list-style-type: none"> • 6.5% poverty rate • Whites predominate to 2040 • Mostly insured • Need health care and community • 25% increase in household income the under-35 population since

Source: IFTF; U.S. Census Bureau.

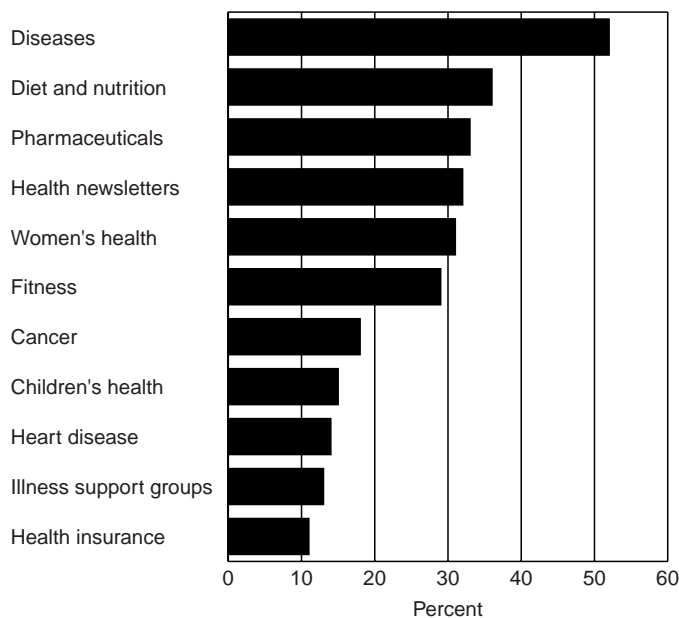
**New Roles
for Technology**

Although they are not the only answer, information and communication technologies can ease the pain and expand support to both caregivers and elders. Recent and emerging innovations and affordable prices will make them accessible for much of the population.

- *The Internet.* Caregivers can now find information and access networks of caregivers across diverse disease states and health conditions. With the emergence of online services such as online pharmacies,

both prescription and over-the-counter items will be easily available to homebound elders and their caregivers. New services can be scheduled and coordinated via the Internet and e-mail, with community service providers as well as friends and family. Since women make an estimated 80% of health care decisions and nearly 60% of health care purchases, many of these online services and sites will target women. More than 70% of the people who are online access health information, and many more information and service options will become available to them (see Figure 3–25).

Figure 3–25
Searches for Health Content Online
(Percent)



Source: Cyber Dialogue, July 1998.

• *Aware environments.* Intelligent environments—homes, rooms, and cars enhanced by embedded information technologies and sensors—that provide the critical information we need, where we need it, when we need it, in a form that we can quickly act on will become more available. Such intelligent environments can offer an alternative to 24-hour caregiving. Aware environments with sensors have applications for monitoring frail patients or family members and transmitting information and data to physicians and family members. Examples of aware environments already exist. As soon as we turn on our digital cell phones, our location is registered on a network. The New York Thruway has a limited awareness of drivers passing through because it can sense the cars that have electronic toll accounts. As the car approaches, the system reads the account balance, deducts the toll, and lets the driver

know the balance only when it is getting low. Imagine an aware environment that can monitor the vital signs and health of its inhabitants and issue signals when certain readings reach cautionary thresholds.

• *Biointerfaces.* Biointerfaces are not too far off. Electrochemical implants under the skin can read endorphin levels in our blood and synthesize more when we reach a depression threshold. Or implants could read our current environmental stimuli and hormone levels, then give us an extra adrenaline boost if we need it to get us through the day. Biointerfaces will also be able to respond to physiological changes, such as heart rate or blood pressure. Biointerfaces will be able to provide alternatives to constant monitoring, enhance our physical beings, and give accurate information to health care providers and caregivers.

A PUBLIC POLICY AGENDA

Reliance on informal caregiver support alone is not the answer to long-term care needs of older Californians. Here are some ideas to consider:

- Revise immigration laws to allow immigrant caregivers to work in elder programs.
- Create policy for respite care, including tax incentives.
- Provide more workplace support so that women (the traditional caregivers) can have flexible hours and places of work.
- Encourage communities to develop local services through microlending programs and special tax breaks.
- Provide incentives for health plans, RCFEs, and assisted-living programs to innovate.
- Support information and communication technology applications for home monitoring and connection with homebound elders.
- Build community support networks for respite care, information exchange, and advocacy.
- Create and support online information resources for caregivers and their families.

**CALIFORNIA'S AGING WORKFORCE:
CHALLENGES AND OPPORTUNITIES**

Now that Californians are living longer, will they retire later? Will they even have a *choice*? The 20th-century notion of retirement is becoming obsolete. Work expectancy will increase with life expectancy. Life expectancy now averages 75 years, and more of these years are productive because of advances in health, fitness, science, technology, and preventive medicine. Retirement age at 65 was adopted in Germany in the mid 1800s, and has set the standard since then. But life expectancy then was only 45 years, and 65 was truly the upper limit to human effectiveness. Today, life expectancy is much higher than it once was, work relies more heavily on cognitive rather than physical functions, and 65-year-olds are still in a productive life stage.

Over the past several decades, the nature of jobs also has changed, enabling older

people to work longer with ease and capitalizing on brains, not brawn. The growth of the service sector, where jobs are less physically demanding and schedules are more flexible than in manufacturing, makes work at older ages more attractive and more possible than in the past. National public policy has already raised the normal retirement age to 70 by 2029 and early retirement age to 65 in 2017; this decision is expected to maintain the anticipated years of retirement at an approximately constant level. Policies to protect older workers have been put in place, such as outlawing both mandatory retirement and age discrimination. Meritocracy, to some extent, is replacing seniority in the workplace. This shift implies both threats and opportunities for older workers. As boomers age, both business and government will face many challenges in this unmapped territory.

OUTLOOK TO 2010

- The baby boom life cycle continues to have huge impacts on all aspects of American life. In the first decade of the 21st century, baby boomers' impact on the workforce will be equally strong. The youngest baby boomer will turn 46 years old in 2010 (the oldest turn 64), increasing the number of workers in the 45-to-65 age category. They will be at the peak of their work life, and their decision to transition to retirement or continue working will have a profound impact on the workforce and larger social issues.
- Retirement will become less predictable. Incentives for retirement are shifting, but the reversing trend toward later retirement will continue at a slow rate over the next ten years. Well-educated older workers who want to stay active in the labor force will drive continued workforce participation. The numbers after 2010 will begin to shift more dramatically. Most of the increase of older workers will be among people age 60 to 65, as the baby boomers retire closer to 70.
- Although older knowledge workers will actively seek continued engagement in the labor force, many other older workers will have no choice. Supplementary income rather than interest will drive single older women, minorities, and individuals who made poor or too-conservative investment choices back into the workforce.
- Job discrimination against older workers will continue but will be masked by the continued trend in California of restructuring the workforce with temporary and part-time jobs and outsourcing. Older workers will be restructured out of the workforce. Older women and ethnic groups will be affected most.
- California will continue its trend from defined benefits to defined contributions, thereby reducing more workers' retirement pensions. This means more retirees will have to rely on earned income, meaning work, to finance their retirement.
- Many older workers will leave the traditional workforce. A new wave of entrepreneurship will emerge. More women in their 50s will start businesses and set themselves up for an income stream in later years. They will opt out of large company workforces, especially jobs in senior management, to gain a greater ability to care for children and elderly parents. Other entrepreneurs will create businesses to respond to the growing needs of the older market.

**Who Will Work Past 60
in the Next Decade?**

The modern model of retirement, in which a person works until their early 60s and then moves abruptly into a full-time life of leisure, is only about a century old. The information age retirement model is more likely to be one in which people shift slowly away from full-time work, over an extended period of months or years. This new retirement model is one that California businesses will pioneer. The state's technology and entertainment industries that boomed in the late 20th century introduced innovative business and organizational models, and the retirees of these companies will craft a different and more rewarding model for a fulfilling life after retirement.

One of the key driving forces behind continued work is the rise of education among older people—a trend that will only expand as well-educated baby boomers age. People who work past 60 and those who don't, when

correlated with educational level, fall into significantly different groups. People with five years of college education constitute the leading edge. Members of this higher-education, higher-income group have a great deal to lose by giving up their jobs. To them, work is not just a job but rather an activity that provides a significant part of the meaning they seek in life: they live to work, not work to live.

Bridging Work and Retirement

Rather than retiring completely, older workers will pioneer new work arrangements in their later years. To earn income and to maintain leisure time, older workers will move into “bridge jobs”—employment between full-time careers and complete retirement. Bridging will be easiest for educated and skilled older workers who will experiment with different types of jobs. Some even will start new careers that will fulfill them for the now very productive years from 60 to 75—and even 80. As the 21st century rolls forward, the number of productive working years past 70 will increase. Working in retirement will not be limited to the educated elders. New programs like the Senior Community Services Program, funded under the Older Americans Act, will retrain elders with low skills who either have to work to supplement their income or want to work to end social isolation and add more meaning to their lives.

**OLDER KNOWLEDGE WORKERS
WILL EXPERIMENT WITH JOBS**

- Older entrepreneurs
- Consultants
- Older executive coaches
- Socially contributing work
- Part-time contingency workers
- “Bridge jobs”

Early Retirement: A Global Trend

Early retirement, leaving the workforce before the legally required age, has been a worldwide trend in the more economically developed countries beginning in the 1970s and 1980s (see Figure 3–26). It became part of the culture of industrialized countries to leave the workforce as early as possible, usually before 60. The 20th century has been characterized by many gains in worker benefits, including social insurance programs, old-age benefits, and other retirement plans—all encouraging retirement. It has also been a century when fertility rates have fallen and globalization has driven a restructuring of organizations and the workforce.

It has also been a century of unparalleled gains in science and technology that have prolonged life. Taken together, these new driving forces of change will reverse these trends. Because countries will be unable to support old-age benefits with the projected changes in worker-dependent ratios, pensions and benefits will dwindle and become fragmented, people will begin to see that they will outlive their benefits, and healthy, active people will want to work longer (see Figure 3–27). The long-term impact of these drivers will alter the landscape of work and lead to vast restructuring in California.

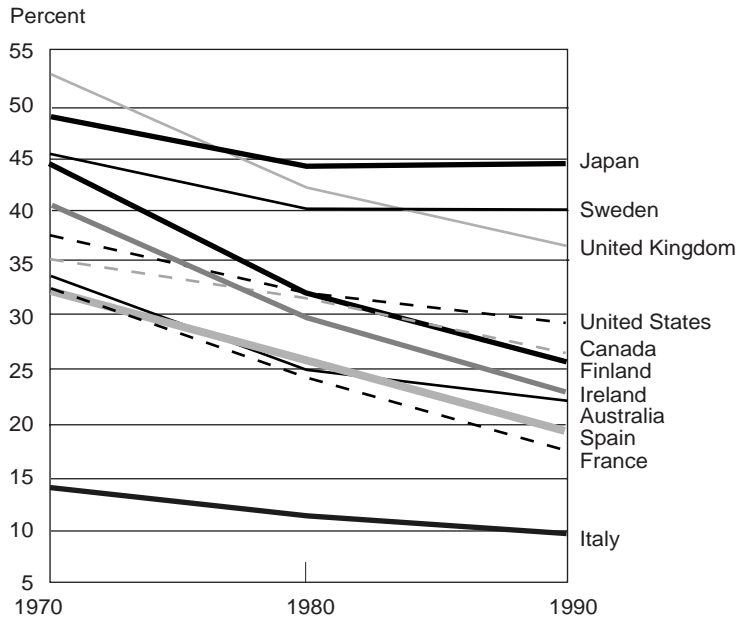
“Retirement means ‘retreat, falling back, privacy, withdrawing into seclusion.’ This definition is out of sync with today’s leading edge of retirement, especially for California’s innovative knowledge workers.”

—IFTF

“In 1950 when the workforce was mostly male, 46% of men over 65 were still working; in 1998 it was only 16%.”

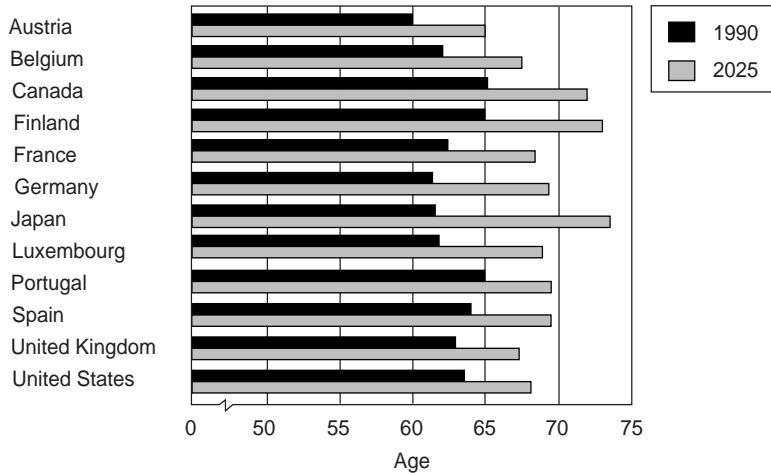
Source: IFTF; U.S. Bureau of Labor Statistics

Figure 3-26
Labor Force Participation Rates of Older Workers Declined in Recent Decades
(People 55+ in 11 developed nations: 1970, 1980, and 1990)



Source: OECD, *Employment Outlook*, 1992.

Figure 3-27
Demography May Alter Standard Retirement Ages
(Retirement age in 2025 needed to maintain 1990 retirement ratio)



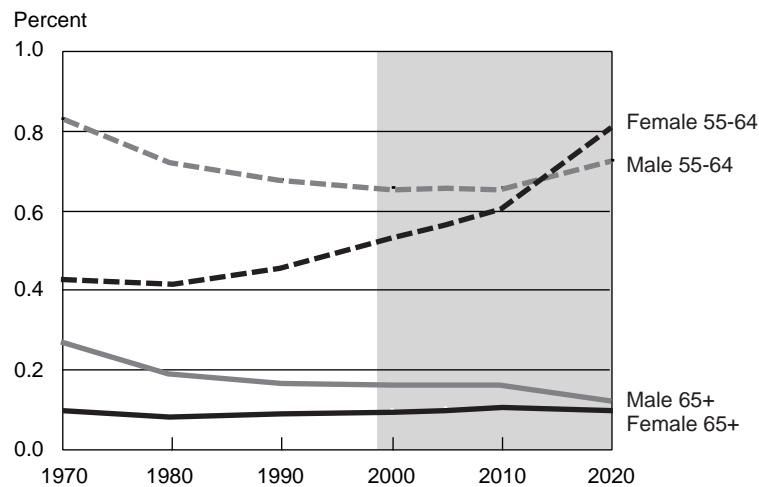
Source: OECD, 1988; U.S. Census Bureau, International Programs Center, International Data Base.

**Looking Ahead at
U.S. Labor Participation Rates:
Expect Discontinuities**

It is hard to find a forecast that displays a radical shift upward in retirement age. The growth in the labor force for ages 55 to 64 over the first decade of the 21st century is due to the aging of the baby boomers. It is unlikely that we will see much change in the 60-to-70-year-old group between 2000 and 2010 (see Figures 3–28 and 3–29). Even with the increases in longevity, most people have

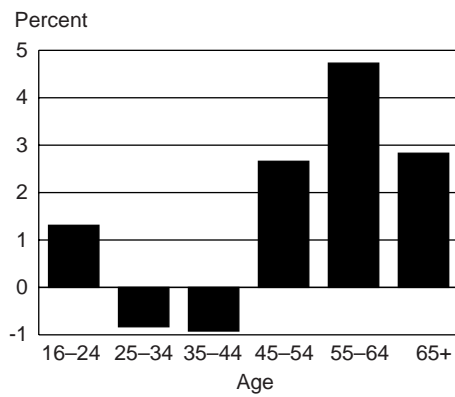
not calculated and made course corrections in their retirement plans. These are the last retirees before the baby boomers, and as a cohort they have more trust in the system. Look for corrections in most forecasts as the knowledge and understanding of the aging of the United States and California becomes a living part of the psyche (see Figure 3–30).

*Figure 3–28
Labor Force Participation Rates Among Older Workers, United States*



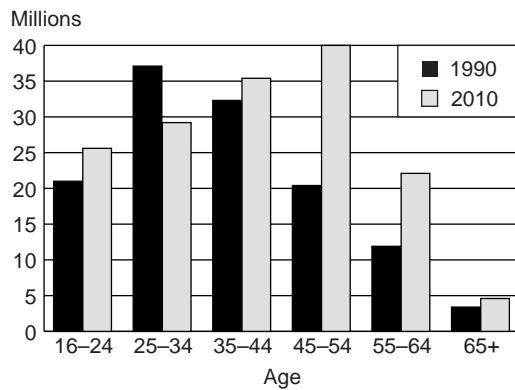
Source: IFTF; U.S. Bureau of Labor Statistics.

Figure 3–29
Growth in the Older Labor Force, United States, 2001–2010
(Average annual percent change)



Source: IFTF; U.S. Bureau of Labor Statistics.

Figure 3–30
The Age Structure of the U.S. Labor Force, 1990 and 2010
(Millions)



Source: IFTF; U.S. Bureau of Labor Statistics.

Challenges and Barriers Remain

Many obstacles remain for workers who need or want to continue to work. Significant age discrimination continues to be found in the workplace. As companies have moved to downsize and decentralize in this fast-paced global marketplace, their CEOs and accountants see their older, higher-paid workers as a burden and seek ways to have them “disappear.”

Barriers to an Aging Workforce

As the knowledge economy evolves, many new work arrangements are also evolving. Organizations are responding to both workers’ preferences and businesses’ increasing needs for flexibility to create options for older workers. Resulting arrangements may allow older workers to reenter the workforce with flexible work hours, at different points in their lives. These older workers may even transition into different occupations, roles, or careers within the organization. Despite these changes, however, many organizations face considerable barriers in responding to the aging workforce. Extend-

ing older workers’ careers, integrating them more efficiently into the workforce, and enhancing their productivity and value in the later stages of their careers means employers must contend with the following issues:

- Increased health care costs of older workers.
- Temptation to save money by eliminating higher-paid, older workers.
- Lingering prejudices and stereotypes against older workers.
- Defined-benefit pension plans that provide incentives to cease work at the time of maximum pension value.
- Special programs targeted at older workers that are sometimes at odds with the Age Discrimination in Employment Act.
- More prominent, competitive considerations that push aside the concerns of the aging workforce, such as higher-priority financial and human resource policies, like those targeted at women, minorities, and entry-level workers.



**CALIFORNIA COMMUNITY READINESS:
REGIONAL MALDISTRIBUTION OF RESOURCES**

California is a large state with a diverse landscape. California is urban, suburban, and rural. Northern California is sparsely populated and has a difficult-to-navigate mountainous geography. The Central Valley is one of the world's most abundant agricultural areas. Southern California is densely populated and has vast stretches of desert. The San Francisco Bay Area and the Los Angeles Basin are California's main population centers; more than two-thirds of the state's population live in these regions.

California's regions and its 58 counties have their own peculiarities and defining characteristics. Great differences also exist in the range and scope of services available to

California's older population across these regions. Health and social service infrastructures vary across the landscape, as do the type and range of services provided within those marketplaces. Regional demographic shifts will continue to be significant in the years ahead, and these will increase pressure in areas that have little infrastructure to meet the challenges of an aging population. The distribution of resources—aging services, geriatric centers, adult day care, respite for caregivers, health centers, and geriatricians—is inadequate today and will be challenged further to meet the anticipated growing demand for services in the 21st century.

OUTLOOK TO 2010

- Regional maldistribution of resources for elders will continue well into the next decade. Only a few elder care programs will be replicated, and building physical and social infrastructure will take time.
- Medicare managed care providers will concentrate in select urban areas and continue to passively avoid higher risk groups and rural areas. Long-term care facilities will cluster near higher income populations; access problems will grow.
- Regions such as the San Francisco Bay Area will continue to offer innovative, diverse programs and services to the 65+ population. Other regions with fewer academic and philanthropic resources will find it challenging to build and offer the range of services available in the Bay Area.
- Policymakers will not address the maldistribution issue. The problems are foreseeable, yet few decision makers will act to prevent them. Businesses that provide elder care services will form to meet the demand. However, the market will respond to demand by clustering around population centers of elders with the means to pay—the San Francisco Bay Area, wealthy communities in Southern California, and retirement areas such as Truckee and Lake Tahoe—ignoring other less-populated areas.
- Southern California will continue to have the greatest number of elderly—and the most fragmented programs. By 2010, 52% of all people 65 and older will live in the Los Angeles and San Diego regions. This number will include 67% of the state’s Latino elderly. Few programs and services will be ready culturally and linguistically to service these populations.
- The San Joaquin Valley is quickly becoming California’s third-largest elderly population center. By 2010, approximately 10% of Californians age 65 and older will live in Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, or Tulare counties. Few programs will be able to cover the vast geography this rural region represents. Because there will be few elderly population clusters, development of community-based services will be a challenge.
- Community readiness for a swelling number of elders will remain a “sleeper” issue, with only a few wealthier communities moving ahead. A small increase in preparedness, however, will be seen in experimentation with service development, particularly in the San Francisco Bay Area.

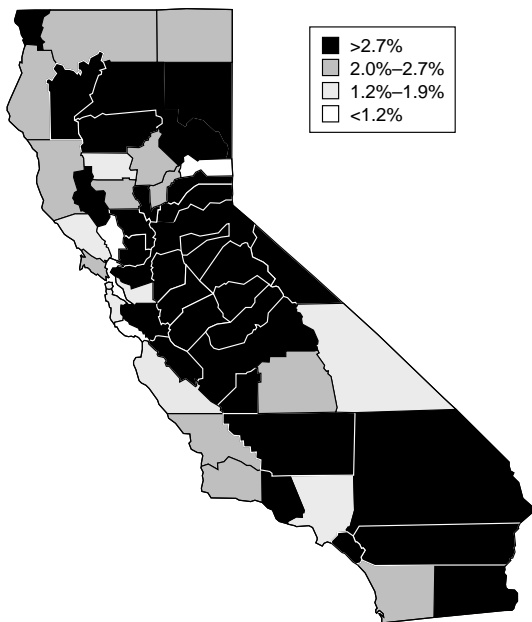
Fastest Growth Is Mostly Inland

Counties in the Central Valley, the Sacramento area, and Southern California will experience the highest average annual growth rates among the elderly. Counties with the highest absolute population increases will include Santa Clara, Sacramento, San Bernardino, Riverside, Orange, San Diego, and Los Angeles (see Figure 3–31). Still, each region will remain unique based on their

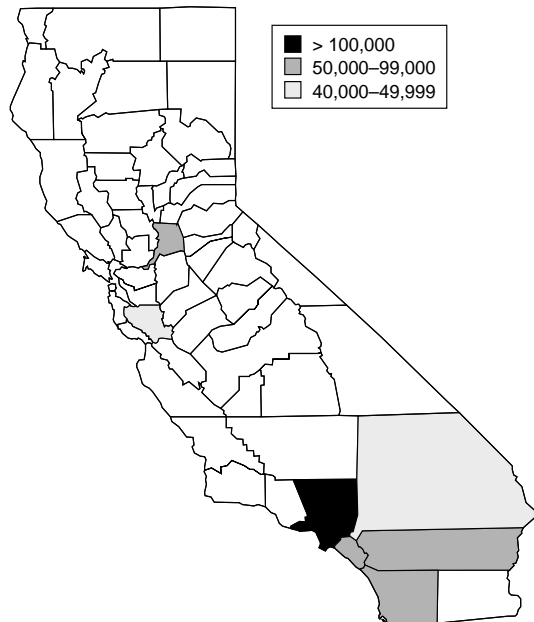
share of the total elderly in the state and the impact that the elderly will have within the region. For example, the Sacramento Valley is home to only 2.6% of the state’s elder population, but these elders make up 15% of the region’s *total* population. Therefore, it will be relatively “older” than the state as a whole, which has a lower proportion of elderly at 10.4%.

Figure 3–31
Growth of Elderly Population Statewide

Average Annual Percent Growth



Absolute Population Increase 1990–2000



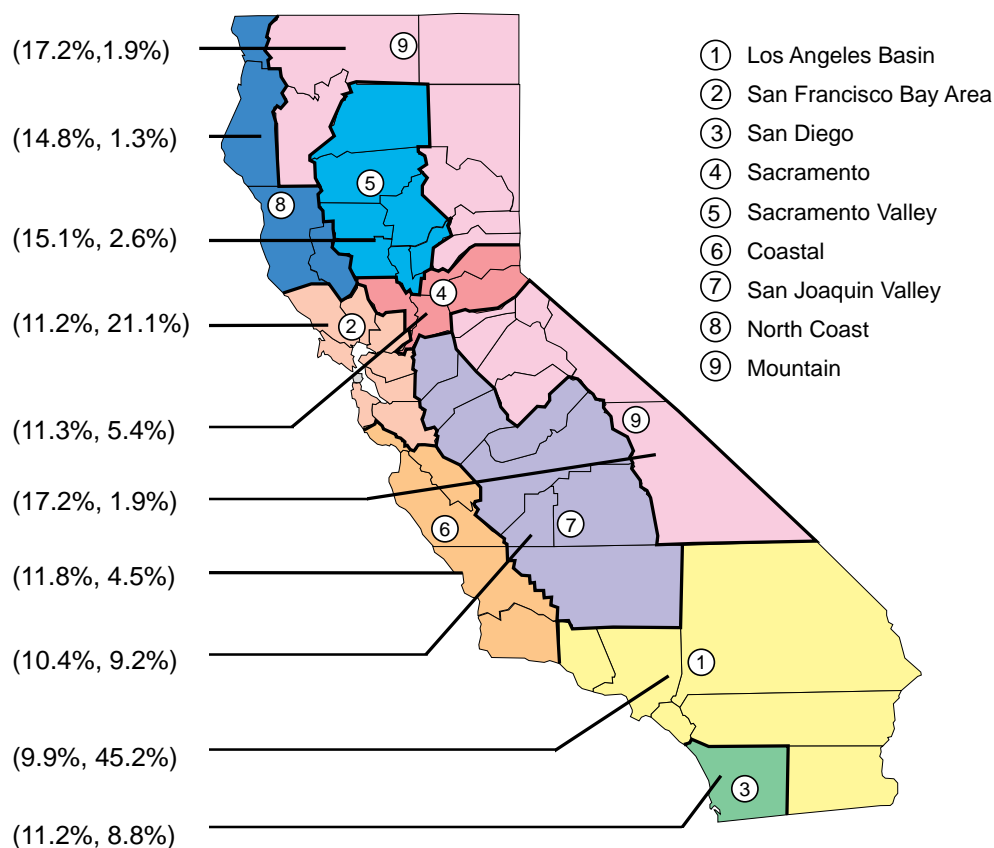
Source: State of California, Department of Finance, *Projected Total Populations*.

Regional Differences

The Los Angeles Basin, the San Francisco Bay Area, and the San Joaquin Valley will represent more than 76% of the state's 65+ population. At the millennium, some 45% of all elders in California will live in Southern California's Ventura, Los Ange-

les, Orange, San Bernardino, Riverside, and Imperial counties (see Figure 3-32). Already, 60% of the region's 65+ population live in Los Angeles County alone. Despite this presence, few Southern California communities are truly "elder-friendly" (see Figure 3-33).

Figure 3-32
 People 65+ by Region in California, 2010
 (Percent of total regional population, percent of total state population age 65+)



Source: IFTF; State of California, Department of Health Services.

The San Joaquin Valley: A Growing Community of Low-Income Elders

More than 450,000 elders will live in the San Joaquin region, only half of the elderly population in the Bay Area, but a significant number nonetheless. These elderly will suffer because the region is primarily rural with few population centers; therefore, service delivery will be difficult. There is also a large disparity of incomes in this region and fewer local resources. The region is also making an effort to diversify its economic base as agriculture has been consolidated into larger corporate entities.

Despite these problems there is rising leadership for economic and social development in the great Central Valley. This movement could be leveraged for innovation around elders.

The San Francisco Bay Area:
The Leader Thus Far

San Francisco, the home of On Lok, the flagship program for comprehensive and continuous health care of elders, has systematically addressed some of the needs of elders better than other regions. Home to a large Asian population of elders and many wealthy older Californians, it has experimented with collaboration among providers and foundations, which has resulted in some pockets of excellence. It is said that providers in the San Fran-

cisco Bay Area have initiated more programs and community-based services per capita than their counterparts in the Southland, with organizations working together closely at the local level.

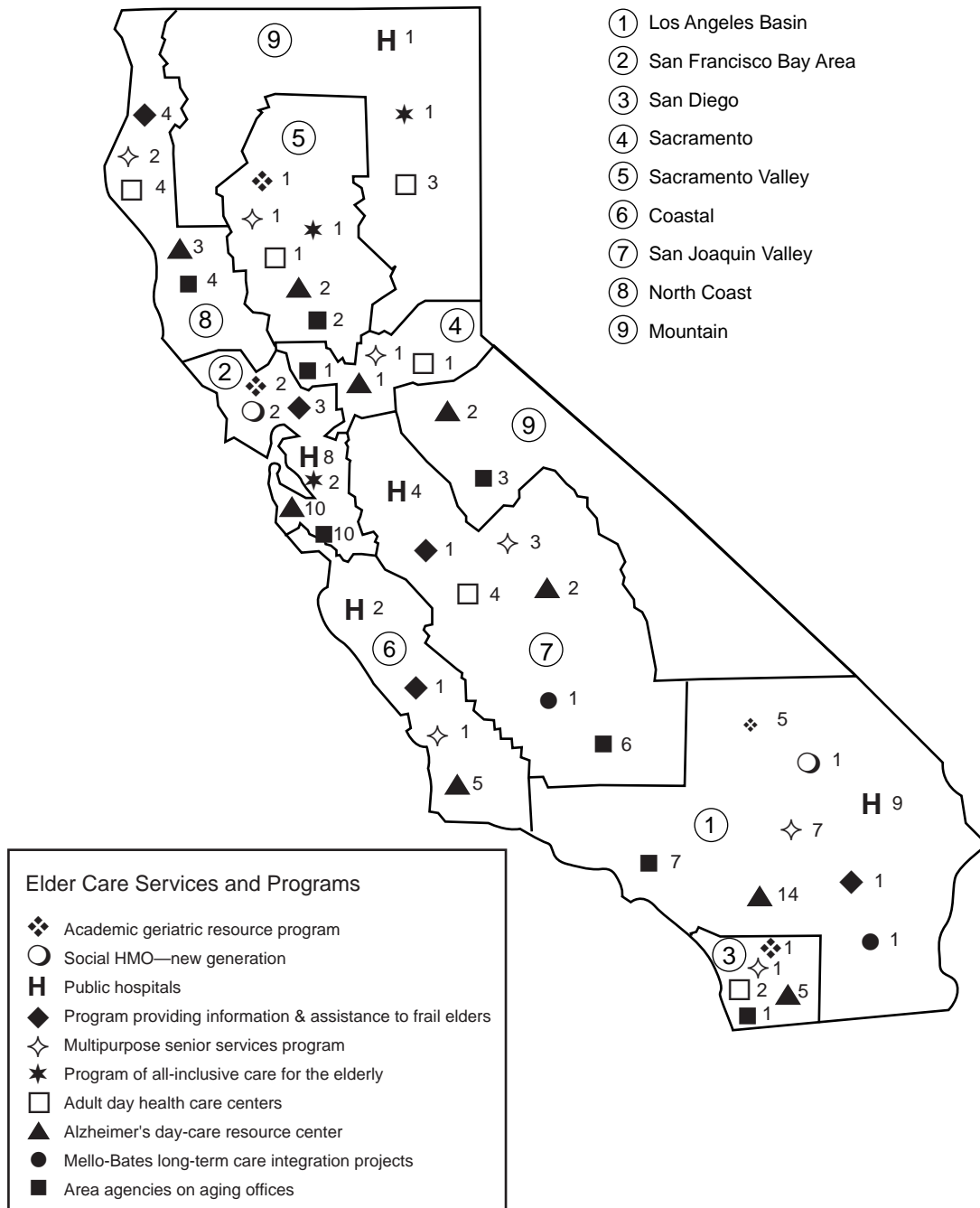
The Sacramento/Redding/
Lake Tahoe Corridors

The “greater Sacramento region” is experiencing growth and has much diversity. It has a lower cost of living and several pockets of urbanization close to rural areas that will support the development of elder services. It could be a sleeper for growth as the cost of living in the San Francisco Bay Area will continue to rise faster than the state as a whole.

Rural California

Many rural counties will experience high percentage growth of elders, but the base is small, except for rural counties in the Sacramento-Lake Tahoe corridor and in the San Joaquin Valley. Rural California has a surprising amount of ethnic diversity. These counties will not see much penetration of Medicare managed care. Most care will have to come from local social networks. These networks will develop in some communities, but others will be suitable for only the hardest and most independent elders.

Figure 3–33
Distribution of Elder Care Services and Programs by California Region



Source: IFTF

“You got to live here to express this point, you got to live here to see what’s goin’ on. You gotta look at history, baby, you gotta look at history.”

—Big Al, as quoted by Anna Deavere Smith in *Twilight: Los Angeles*, 1992

THE LOS ANGELES BASIN: THE MOST CHALLENGED REGION

More older Californians live in the Los Angeles Basin and San Diego than in any other area, and both areas can expect their elder population to grow in the future. By 2010, they will be home to over 50% of all people over 65 in California. In both regions, growth is further complicated by the increasing diversity among older populations. Los Angeles is in the process of a large-scale ethnic transition, and the number of ethnic elderly increased rapidly between 1980 and

1990. There has been a 32% increase in African Americans, a 162% increase in Asians, and a 56% increase in Latinos, with Latinos projected to remain the largest group in perpetuity. There is little availability and uniformity of data to complete much meaningful analysis, but many experts believe that fewer developed resources are available in the southern part of the state. The lack of available data makes such estimates hard to quantify for any region.

THE LOS ANGELES COUNTY ELDER CHALLENGE

- The majority of elder immigrants are from the second wave of immigrants, who followed their children in the 1960s and 1970s and are not citizens.
- The county has more than 100 different languages within its borders; the elders most in need have English as a second language or don’t speak English at all.
- An anti-immigrant, anti-minority atmosphere prevails.
- There is a culture clash because Los Angeles is the capital of the youth culture.
- Many will compete for attention—residents have the highest rate of poverty, creating incredible and conflicting demands for public services.
- There is a severe fragmentation of services; mismatch of services to location of population is exacerbated by a poor public transportation system.

Guiding Principles

FINAL THOUGHTS

Attitudes and values about aging are rooted deeply in American culture. Most of them no longer fit the new reality of aging that emerged in the 20th century, but they are hard to dislodge, especially in California, which is so focused on youth. The long-term drivers we describe in this report will be powerful mechanisms of change over the coming years, but their impacts are not yet felt at a seismic level high enough to make the fault lines in the aging landscape visible to most Californians.

The full impact of the human tidal wave of older Californians will reach the shores of California between 2010 and 2020. But today the fault lines are already emerging and beginning to change the entire landscape of California. In them we can see the unmistakable signs of change, the points at which the underlying demographic pressures and the economic, social, political, and technological changes are converging to change the contours of the world of growing older in California. In them we can catch a glimpse of the future. The pioneers, those Californians who will be the first to live beyond 80, to 100—perhaps 110—will have important stories about their journeys in this uncharted territory. We need to listen to their wisdom. There are millions of people lining up behind them to take this journey.

The first ten years of the new millennium will be a critical time in which to plant the seeds of solutions to grow more successful aging in the Golden State. There is much to be done. Every area of the territory needs cultivation and attention. The need for change is large in California, because of the scale of its aging population, the fast pace of growth, and the diversity of its people. We need to start anew by crafting some

principles to guide the cultivation of California as a better place for growing older. We must not hurriedly implement narrow programs and strategies in the face of the complexity and the size of the underway shifts. We need leaders to come forth—people who can see and articulate the big picture and a framework to guide all the millions of little things that need to be done in every community, in every organization, and at every level of government.

We offer eight guiding principles as navigational aids to leaders—politicians, community business leaders, government bureaucrats, and foundation executives—who have a passion for creating California as a place for successful aging, and who have resources to invest. These principles serve as a starting point, a place to begin a dialogue about the big changes and issues and to initiate strategic action—action that moves us forward in the right direction and picks up the pace of change. We hope these principles will be built upon and modified by the wisdom of others. With each guiding principle, we suggest seeds of solutions and strategic steps, which are opportunities for action that seem both important and possible, on which to begin working.



INVEST IN THE EDUCATION AND DEVELOPMENT OF CALIFORNIA'S DIVERSE YOUTH

Many people might think it odd that the first guiding principle about aging focuses on youth. Long-term investing in the Golden State's ethnically diverse youth is one of the most important actions that will ensure the quality of life for elders and the continued prosperity of the state. The potential payoff is big.

Over the next several decades, California's ethnically diverse young population will grow into adulthood and form the core of the workforce. This great transformation is exciting and dynamic while at the same time challenging. Traditionally, over the course of two to three generations, ethnic groups, particularly Asians and Latinos, "catch up" with the white population in terms of education and work skills. However, this process is

slow and not fast enough to meet the changing needs of the state.

Current high school dropout rates are high, and the percent of ethnic youth who enter college is low and growing at a snail's pace. Given that today's ethnically diverse youth will make up the majority of the workforce over the next few decades, it is important for California to invest in supporting the completion of their education to ready them for a full range of jobs—including top-level management and professional skilled careers. It is in the best interest of California that these youth perform well academically and take less than the usual "multiple-generation" length of time to attain higher education and skill levels. It is important that today's youth leapfrog tradition.

SEEDS OF SOLUTIONS

This challenge deserves a thoughtful comprehensive initiative. Leadership must come from a broad coalition that crosses ethnic groups that are knowledgeable about this complex issue and fully understand the range of solutions.

- Focus on the young Latino workforce; they will play a key role in supporting the retirement of baby boomers. The involvement of business will be a key to the success of any initiative.
- Initiatives should seek to bring the earning ability of these young workers up to par with other U.S. workers
- A major public educational effort must be launched. Most Californians are woefully ignorant of the monumental demographic shifts and their consequences for the state.

The structure of our society makes older people dependent on the successful workforce of and economic participation by the young. This intergenerational dependency has many dimensions, including a certain threshold of taxes. Without this tax base there will be a decline in the capacity of the generations to support each other. Investing now in the education and development of California's diverse youth population will move us closer to "aging" successfully as a state. Otherwise, older Californians will be denied a secure future in retirement.

"A decade ago ... in an important but little noted book called *The Burden of Support*, written by David Hayes-Bautista ... [he] argued that in 1988 two social trends would shape the future of Social Security: the aging of a well-educated generation of baby boomers who will retire in the early part of the 21st century and the growth of a younger, less educated Latino population that will be a majority of the American labor force."

—*Los Angeles Times*, March 29, 1998



BUILD A KNOWLEDGE FOUNDATION ON AGING

The universal lack of adequate data in the field of aging in California has significant repercussions throughout the state—for service providers, the general public, and elders. Accessing information is difficult because existing information is fragmented and dispersed. It is very hard to find information on existing programs at the community level and almost impossible to find detailed statewide data.

Multiple assessment and evaluation tools for services and programs further compound the lack of uniform data for demographic, social, and economic measures. These “tools” are a burden to the service recipi-

ents, as well as to the providers and the caregivers. Counties, programs, and providers are guilty of remaining “siloed,” and they do not address these issues across programs. The state must support any solution to this fragmentation problem.

Although some useful statewide data do exist, useful data about older ethnic minorities are almost nonexistent. Ethnic elders will constitute one-third of California’s 65+ population by 2010, yet they remain relatively invisible to those outside their own communities. Asians and Pacific Islanders are lumped together in one category, which makes analysis of the many subpopulations, from the Chinese to the Filipinos, impossible. Ignorance, myths, and stereotypes abound.

This information fragmentation prevents leaders from seeing the “big picture.” At the moment, it is difficult to describe the current situation or to think systematically about the future because of the lack of usable data. Combining California surveys with some good ethnographic studies of various subpopulations—including ethnic minorities, gender and age cohorts, and disability groups—in addition to cataloging data and information on existing programs and services would help everybody see the big picture. Unfortunately, extrapolating from national data often distorts rather than clarifies the picture in California, because of the state’s uniqueness. Primary data are necessary to educate senior decision makers, the media, and the general public. Without this basic knowledge it will be hard to address any of the critical issues in California.

SEEDS OF SOLUTIONS

Support a public-private task force to implement a statewide project to coordinate, collect, and consolidate information. Establish a moratorium on new data systems at the state, county, and regional levels. Release data early and often on the Internet.

- Mine the U.S. Census Bureau data about subpopulations of older Californians, and form a comparative profile of how Californians differ from other Americans.
- Using existing information from a multitude of programs and national data sets, establish a database on ethnic minorities. Supplement it with a substantial amount of ethnographic studies.
- Develop a set of uniform definitions that are framed in terms of integrated programs. When a person enters the system, his or her information should be usable across diverse programs and services.



FOSTER THE DEVELOPMENT OF LEADERSHIP IN AGING

The lack of effective leadership and innovative thinking potentially could be the most damaging factor in the field of aging. More than anything else, the field of aging needs some new thinking and a set of fresh perspectives that will transform existing mindsets from viewing old age as a medical condition to seeing the great human potential of those past 65.

Aging in California needs a new agenda. This can be achieved only by convening new, innovative groups with a fresh outlook on existing issues and processes. Initiating new

dialogues and explorations of emerging issues will help refresh existing points of view. Some very basic questions will be the building blocks of this type of inquiry: Who is old, anyway? There will be increasing diverse lifestyles among people 65 and older. Most will have only age in common. What is the meaning of old age? How can we as a society learn to value old age and the contributions of older Californians? How do we separate definitions of old age from work or health status? How do people 85+ meet their basic needs and self-actualize?

SEEDS OF SOLUTIONS

- A leadership program should be set up with some characteristics similar to the MacArthur Fellows program. The program would identify and invest in exemplary leaders and innovators in the field of aging in California and begin to build a community of knowledge from the innovations in.
- Convene a small, diverse group of women leaders from areas other than aging, brief them, and enlist their help in creating strong women's leadership focused on key issues affecting elderly women.
- Provide educational scholarships to support higher education for older Californians. At 65, many will have time for new careers or roles in their communities.
- Help ethnic elders groups form coalitions with mainstream providers and get ethnic representation on community boards.



CHIP AWAY AT ESSENTIAL PUBLIC POLICY

Kee expectations realistic and practice strategic incrementalism at the federal and the state levels. In general, public policy making is not a rational process but a response to crisis. There is no perceived crisis at the state level, and most people feel there has been progress in Medicare and Social Security. Over the past 15 years, there has been little strong legislative or administrative leadership on the subject of aging at the state level. There has been no aging advocate since Senator Mello. Unfortunately, changes in public policy are the only true solutions to some of the thorniest problems in aging, such as health care, income support, and housing for the old poor, and little can be done without effective political leadership. Maintaining a variety of approaches to working with senior legislators to increase their attention to transformational aging issues in California is criti-

cal but not sufficient to manage the needs and support the lifestyle of the coming human tidal wave. Unfortunately, given term limits, few policymakers will be in office long enough to become educated.

Too often we divert too much attention to policy solutions. Many problems that could be solved by rational public policy are longstanding, such as the need for integration of services. A gridlock of multiple programs, each with their own turf, is a sad legacy of piecemeal legislation and public policy over the past several decades. There is little hope that a rational approach to allocation of resources will take place over the next ten years, particularly in the medical and health areas. That is why it is important to shift to strategic incrementalism and to chip away at public policy.

The real choice is probably between doing nothing, resorting to ad hoc, piece-meal changes, or moving forward with incremental reforms undertaken in the framework of a broad strategic vision.

SEEDS OF SOLUTIONS

- Revise immigration policy to attract foreign caregivers for the many vacant paid-service positions.
- Craft legislation for respite care for caregivers.
- Chip away doggedly at all barriers that prevent older people from working. Retirement age will need to rise for most.
- Push for a drug benefit for Medicare and accelerated risk adjustment policies by the Health Care Financing Administration.
- Provide incentives to health care plans to network with community programs, innovate for frail elders, and accelerate integration programs.
- Focus on implementation of policies already in place, such as the implementation of the Mello-Bates Long-Term Care Integration pilot projects.
- Identify a small number of potential legislative leaders and educate them about aging issues. Target legislators who have large elder populations in their districts, and brief each member on three or four key policy actions that would help their constituents.
- Focus more effort at the local political level. County supervisors, mayors, and councilmembers need to respond and act positively. Aging is a natural process that is best supported by more social infrastructure at the local level.
- Look beyond medical issues to housing and employment policies. Implement housing policy that enables those aging in place in HUD housing to stay in their “homes.”



EDUCATE THE PUBLIC ABOUT SUCCESSFUL AGING

California is not prepared to meet the demands of an aging society. There is little public awareness, let alone understanding, of the changing aging process and its implications for the 21st century. Outside of Social Security and Medicare, there is gen-

eral apathy about aging programs and a tendency to think about aging as a pathological process that requires medical care. Most Californians seem tied to myths and lack an understanding of the transformed aging process. Senior advocates have not communicated well with or educated the general public about their needs, although they have successfully lobbied for the continuation of Social Security and Medicare programs.

SEEDS OF SOLUTIONS

Most educational programs now focus on training health workers, such as physicians, nurses, and home health aides. These efforts are necessary, but they are not sufficient to address the real issue. And these investments should not detract from a much larger investment of educational dollars into public education. A sea change in attitudes, values, knowledge, and public action is needed. This is where the real return on investment will come from.

- Work to transform the public perception of aging, focusing on the positive aspects of the aging process while combating negative media images of older Californians.
- Create an “aging index” that rates communities by their ability to support successful aging. Rate the best and worst communities in California and use this rating system as an educational vehicle.
- Convene a small group to begin developing a media strategy for educating the public. Find a celebrity to become a champion for California’s elders.
- Initiate a campaign that redefines aging, old age, retirement, and disability.
- Direct education at businesses to engage them in changing their attitudes and practices regarding older workers. The border between work and retirement will continue to blur.

Longevity is the most undercelebrated success story of the 20th century. The promotion of successful aging and a redefinition of aging are the major educational efforts most needed in the state.

Older Californians will begin to shape the future of the state in new and profoundly different ways. As aging profiles change, there will be inevitable discontinuities with the past. This public education initiative should focus on health, successful aging, and the changing meaning of growing older, profiling the new older Californians. Public education should be conducted in a way that enables individuals and families to change their minds about aging and initiate changes in the fundamental ways they prepare for it. Successful aging in California must be built from the individual up.

In a very real sense, longevity is the most undercelebrated success story of the 20th century.



DIRECT THE MOST ATTENTION TO OLDER WOMEN

Women will be the most vulnerable sector of the elder population, especially those age 80 and older. Shouldn't special attention be paid to the group that constitutes 75% to 90% of the aging population? Special initiatives are needed to support greater understanding of elderly women's roles in the family and society, and their special needs. Many middle-aged women are poorly informed about their longevity and their health and welfare challenges in old age. Successful aging for women is possible only if women take action in early middle age. The income, health, and social challenges increase more rapidly as they age—and at a time when they are least able to cope adequately with them. In the future, older women are likely to become a leading force for changing aging, particularly over the next 20 to 30 years as the baby boom generation ages. Until then, 20 years out, without major initiatives there will be a serious gap between knowledge, services, policy, and community support.

“The changing demographics of California over the next several decades will result in an older female population that is increasingly multicultural and multilingual. Older women need and want health care and social service providers who are sensitive to their gender, their age group, and their ethnic and cultural background.”

—Deborah Reidy Kelch,
The Health of Older Women in California

SEEDS OF SOLUTIONS

- Address the widow's gap in federal benefit programs.
- Create a focus on housing for older single women.
- Build a coalition of California's women's organizations to address the issues of vulnerable older women.
- Develop community programs that build bridges between younger and older women.
- Create a special focus on older women of color.
- Support ethnographic research that unveils the true lifestyles of older women and provides a framework for understanding and addressing their needs in subgroups.



INNOVATE AT THE FAMILY AND COMMUNITY LEVELS

To age successfully, most Californians will rely on family and local community efforts. Yet the family and the local community are the areas that require the most experimentation. No one knows what a good aging community is for the average elder family. There are too few visible role models at both the family and the community level to learn from. In America, aging is not something we look forward to, so it receives little positive and innovative thinking. Bold initiatives and out-of-the-box thinking are required.

How can neighborhoods work to support aging in place? How will communities with large aging populations remain economically viable? How can technology be used on a community level to keep older people interconnected with friends, family, and services? Churches and other community organizations will have to create communities that are conducive to aging. This calls for sea changes in how we think, act, and live in every community across the Golden State.

SEEDS OF SOLUTIONS

- Explore microlending programs for communities with lots of aging members, especially in low-income or poor counties. Stimulating local enterprises and new financial products will be important strategies to help elders leverage the assets they have.
- Identify and invest in a few potential model communities to create alternative models.
- Develop matching funds programs for communities interested in improving their rating on the “aging index.”
- Broadcast some of the truly exemplary innovations that work and offer potential models for California from around the world.
- Find a community that can be “wired” to the max. Create a high-tech model community of the future, using the power of technology across issues and needs.
- Build relationships between ethnic organizations and mainstream groups.

“The most useful social capital is not the ability to work under the authority of a traditional community or group, but the capacity to form new associations and to cooperate within the terms of reference they establish.”

—Frank Fukuyama,
*Trust: The Social Virtues
and the Creation of Prosperity*



ADDRESS POVERTY AND MALDISTRIBUTION OF RESOURCES

The most rapid growth of older Californians will occur in the inland counties, as people migrate away from the more expensive coastal areas. However, although the people move, the money stays on the coast. Many local governments will feel unable to meet an aging population's needs. California must not be divided between good and poor communities for aging based on income, race, and geography.

Although most elders will not be “officially” poor, there will be significant pockets of poverty. It is likely that a new definition of what constitutes poverty for old people will be developed. Being poor and sustaining a reasonable lifestyle is a challenge at any age, but it is simply overwhelming if you are old. The ability to create workarounds, to supplement income, to barter for goods and services, and to maintain activities of daily living diminishes with age.

SEEDS OF SOLUTIONS

- Create a new index of poverty and aging for California. Take into account California's cost of living and different formulas for purchasing power.
- Initiate new public policy that helps to redistribute state revenue to communities that have mismatches between elders, income, and services.
- Create models of building services for middle- and low-income rural and urban communities and ethnic groups.
- Explore opportunities to develop work for older people at the community level as a resource generation solution.

CRAFTING A CALIFORNIA SOLUTION

California is in a unique position to invent its own solutions to creating a place for successful aging. As the world's seventh-largest economy and the leading state in innovation, California has the financial and intellectual resources to do the job. As a microcosm of the global aging phenomena engulfing the planet, it has the opportunity and responsibility to take its experimental and risk-taking culture and cut a path forward that is inclusive of all its diverse older people. The distance between today's status quo and the arrival of the human tidal wave of elderly could be alarmingly short or surprisingly long. It all depends on how well-prepared California is—and the sustained and innovative participation of many key players. There is a lot to be done. Let's get to work.



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